



COUNTY COUNCIL OF THE WEST RIDING
OF YORKSHIRE

SIXTY-FIRST
ANNUAL REPORT

OF THE

County Medical Officer

AND FORTY-SECOND ANNUAL REPORT

OF THE

School Medical Officer

YEAR 1949

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(as at 1.11.1950)

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INTRODUCTION

Health costs money and like every other saleable commodity must follow the laws of commerce. We buy what we can afford and the best for the money. What we can afford is a matter for the financiers and in their calculations they must include the value of the individual to industry. When money is spent on health there is a set off in the amount recovered by reason of the output of work of a healthy individual in contrast to his dead loss when totally incapacitated and his reduced efficiency when below par. The value of this "set off" is greater in times of "full employment," for there is no pool of unemployment to which to debit the cost of his working loss. There is also a saving of cost of treatment when money is spent successfully on prevention. A nation living on its industrial effort cannot neglect this issue. The Minority Report of the Working Party on Nursing, showed that an improvement in the staffing of general hospitals by the employment of more fully trained nurses gave an economic return in the speedier discharge of patients to industry. All or most of the operations of curative medicine are capable of similar examination though it is doubtful whether the balance sheets would always be favourable. *The cost of health.*

The same approach is possible to "Public Health;" its operations can also be subjected to the inexorable searchlight of costing. Some will pay, some will not. An examination can be made of the cost of institutional treatment of diphtheria. Between 1935 and 1939, 12,390 patients from the West Riding were notified and 11,770 (approximately) were admitted to hospital. This entailed the full use of 317 beds annually. Between 1945 and 1949 the number of patients admitted with diphtheria to hospital was 2,340 entailing the full use of 61 beds annually. The estimated cost of treating a case of diphtheria in a fever hospital has been given as £40 a case (page 4 of the Report of the Committee on the Cost of Home Information Services); the reduction of cases admitted to hospital, therefore, represents a saving of £75,000 a year. Over and above this there is the saving represented by the nurses and domestics who can be engaged in productive work. The 256 beds no longer required represent a saving of 64 nurses and 70 domestics; on the basis of the average worker's product being £400 per annum (paragraph 127 of the Minority Report on the Training and Recruitment of Nurses) the estimated saving in money from this source is £53,600. Furthermore, the number of deaths from diphtheria in the five years 1935-1939 was 734 and in 1945-1949, 65, a saving of 669 lives. Various estimates have been given by economists and actuaries of the cash value of a life. Before the war it was estimated that the value of a child aged five years is £200, that of a person aged twenty years £800. On this basis the estimated cash value of the lives saved is about £213,000 on a pre-war basis, or, say, £43,000 a year; it may very well be higher to-day. The total annual saving, therefore, is £172,000 a year. As against this, we have to place the cost of immunisation itself, which probably does not exceed £10,000 a year. The monetary saving of this single operation in preventive medicine, therefore, exceeds by £10,000 the estimated cost for 1950-51 of the whole of the Health Visiting Service. *Preventive Medicine can save money.*

We buy what we can afford and since the purse is not bottomless we soon come up against economic barriers which cannot be got over. This makes the second law (we buy the best for our money) of the greatest importance. When we say we buy the best we mean, of course, that which on balance gives us the best return in industry. This is not wholly to ignore the humanitarian aspects, nor the abstract value of happiness, for the best that the health service can do for any man is to make him an effective working unit, paying his way and achieving happiness in service. If we demolished all our slum dwellings, doubled our sanatoria, and created family colonies, like Papworth, in every county we might reasonably expect to abolish tuberculosis in ten years. Great as would be the ultimate economic return the immediate outlay would be heavy and so we adopt less heroic measures. With a limit to the amount of money to be spent on health services and a determination to spend money on those things which give the best economic return, we cannot escape from the need to make choices between varying alternatives and one of the most fundamental of these will be that between prevention and cure. *There must be a balance in expenditure upon prevention and cure.*

Money spent in the prevention of disease is richer in economic return than the same sum spent in its cure; indeed, if our health services were to be put on to a complete business footing the financiers might insist upon a total mobilisation of our forces into the preventive field. There are, of course, many reasons why this is not done; the centring of medical thought upon disease and its treatment has not encouraged the public to appreciate the possibilities of prevention, the glamour of sickness and its drama in our lives, the forcefulness of the concrete and the difficulty of comprehending the abstract, the element of mystery in the compounding of remedies, in the stethoscope, the microscope, the surgeon's knife and the post-mortem room, the greater ease with which an economic return for treatment can be calculated. Fortunately for our peace of mind there is no likelihood of the adoption of such a proposal; we are not in a position now to prevent all disease; we shall not see our sick allowed to die for want of surgical or medical care while the nation turns its whole attention to the eradication of the slums in which disease is engendered and the teaching of physiological and biological principles upon which health so largely depends. Yet it is important to secure a balance of expenditure on these two aspects of medicine; there is little likelihood that we shall ever neglect individual health; are we certain to observe a proper concern for community health? *The difficulty of the choice.*

This difficulty is increased by the creation of separate authorities.

In the administrative machine created by the National Health Service Act, 1946, the cost of health in any particular area has been divided among a number of different authorities. The duty to apply medical knowledge to the prevention of disease rests with the local authorities; theirs is the more difficult task. The division of responsibility carries with it the risk that there may be no overall concern for the expenditure of money in relation to the community health, and money may be spent in ways which are less beneficial in terms of its health yield than others. There is now some preponderance of expenditure upon the curative services (e.g., dental treatment); the cost of dental treatment to the general medical services in the West Riding was approximately £1,084,000 in comparison with £72,397 spent on the preventive dental services to school children.

There are reasons for believing that expenditure now is not balanced between prevention and cure.

It is doubtful whether maternity accommodation is now economically used. Institutional midwifery is a costly process amounting to 15 to 20 guineas a week; in terms of health it has nothing to offer over a well conducted home delivery and in terms of society it is at least doubtful whether it improves family life; it should be reserved for women who need institutional treatment on medical or social grounds and it should be regarded as essentially a preventive institution to protect the community health. With the present division of responsibility these economic and social considerations are in danger of being overlooked. To ensure an economic return for many services which care for the community health the health authority must be able to make proper use of certain institutions. Can you be businesslike when one authority controls the roundabouts and another the swings? Another illustration of the danger into which we may be falling is illustrated by tuberculosis, one of the great scourges still remaining to be eradicated. Its spread in the community depends on a complex of factors related to the environment and the sanatorium is fundamentally one of the weapons to alleviate the adverse factors. Is it good business to charge the community Health authority with the duty to combat this evil and to deprive it of the right to provide sanatoria? These examples might be multiplied many times. Money spent upon nursing the sick in hospital must be correlated with that laid out upon services for care in the home; money spent upon the care of anyone in hospital may be wasted if follow-up and after-care is defective; money spent upon the mental defective in a colony must be accounted with that spent on occupation centres, home teaching and home supervision. Is it better to build out-patient departments at hospitals or health centres within the community?; the answer may be both but it should be according to an integrated plan assessing the benefit of one or the other in terms of an overall provision for community health. If we are to run our health services as a business, which ultimately is both desirable and indeed essential, then we shall find integration under one authority indispensable.

If we had unlimited money this would not matter so greatly; when money is tight it matters much. Can we afford to spend so much on the institutional care for normal midwifery when beds for the chronic sick are as yet so far below what is needed?; is all that we are now spending on ambulance services justified in its economic return in health, while bad housing still remains a fundamental source of ill-health and sickness?; is a separate form of home visitation for foster and boarded out children economically sound?; is it financially sound to have children's homes without spending money on the problem families from which the community of homelessness springs?

The progress of the West Riding Scheme of Divisional Administration.

I spoke in my last report of the expanding scope of executive social medicine and my report to you this year contains details of the first complete year of our divisional scheme which in essence is an attempt to put this new gospel into practice. The outstanding characteristic of the West Riding scheme is that it brings social medicine down to earth by the application of a trained medical mind at the executive level. Each of your divisional medical officers is in a position to take his coat off and get down to the fundamental causes of ill-health in an area which is not too large for him to study and understand the intimate details of life in the home, the school and the factory, and he can be in close personal relationship with doctors and general practitioners responsible for treating sickness. When our scheme was started there was no certainty of what would be the best size of area in which to practise the new social medicine, but I remain convinced that the area must not be too large and in measure, as our services expand, the need for a reasonably compact workable area is likely to be more fully appreciated.

The new opportunities of executive social medicine.

The Medical Officer of Health must be in a position to get down to the basic facts of community life. Wherever there is a weak link in the chain of causation for disease and ill-health he must be able to apply pressure to break it. With his team of auxiliary workers he is in a position to educate in health in the homes of the people, in clinics and in schools. The education of the canteen worker in personal hygiene can, for example, give a good harvest in the promotion of health and a rich return in saving of industrial man hours and hospital beds. As school medical officer he can take part with the teacher in the formulation of a health programme in schools. The medical officer of health in 1950 is a social worker par excellence, seeking to strike at the root of disease by changing the living conditions of the people. Every problem family is a unique case in social medicine; every premature baby born in his area should be in its cot specially prepared within seconds of its birth. Every illegitimate conception not regularised by marriage is a challenge to his ability to secure a full life for the infant and rehabilitation for the mother. Every handicapped child is his personal concern to secure full education during school life and a happy placement in industry. To take

one example out of many—the epileptic; what a worthwhile task these children present; to secure the sympathy and understanding of the teacher, to secure full and continuous medication by helping the parent and the family doctor, to assist in settling him in congenial work through visits of study and explanation to his work place. It is by such means that social medicine can cut down the tragic waste of the epileptic industrial derelict. The Medical Officer of Health must make a continuous study of the epidemiology of our ageing population; the remaining problems of community infections such as tuberculosis, food infections and virus diseases; the epidemiology of stillbirths and premature births; the increasing incidence of degenerative diseases such as coronary thrombosis. As the late Professor Ryle of the Institute of Social Medicine, Oxford, has said “Social medicine must now have regard to the whole range of man’s afflictions.”

The science and art of medicine has created the gospel of the “doctor-patient relationship.” The fundamental concept of executive social medicine is the “doctor-community relationship.” The medical officer of health thinks in terms of the community. It is the fulfilment of this ideal which your divisional scheme has sought to achieve. Unfortunately, there are limitations created by legislation which make it difficult wholly to accomplish. It is a striking fact that Parliament has not yet fully grasped the importance of the doctor-community relationship. Had this been so we might have seen the medical officer of health placed in charge of all social medicine in his area, much as the priest is in charge of the spiritual welfare of his parish. As social medicine has expanded in scope too often new administrative machines have been created. The tendency has been, as it were, to diagnose and treat the organs of the body corporate as if they had no relation to one another. In fact, the relationship between the ills which afflict the body corporate is as close as in those which affect the individual. Consideration for one leads to consideration for another; failure to relate the action taken for one can be detrimental to the work of the whole.

The relationship of the Medical Officer of Health to the community.

Few problems of social medicine are capable of satisfactory solution by independent units; they intertwine like the branches, which they are, of one living whole. The importance of this one fact needs to be more generally understood and accepted if executive social medicine is to play the role in our community life of which expanding knowledge makes it capable and it must not be supposed that independent medical advice can give the integration which is essential to success. There must be an end to the process of dividing up the field of executive social medicine such as has recently been seen in the separation of the care of the deprived child, the aged and the handicapped. It will be disastrous if yet one more watertight compartment is created for the social medicine of industry. It is essential now to make effective health units under the executive control of the medical officer of health, with staff to meet all the problems of community health within it.

The interrelationship of problems of Community Health.

Conclusion

Many of the improvements in our service about which I have spoken in earlier reports, are now in operation and are referred to in the body of the text. Many others still wait upon the seemingly endless delays associated with the new and complicated administrative structure of our National Health Service. The appointment to our preventive services of specialists in child health and the separation of children’s work from midwifery are two examples of delay, the inevitable consequence of our elaboration of the administrative structure. The Council gave their approval to these steps, not months, but now years ago. We still await the necessary approvals from other units in the health service. We heard so much of the inadequacies of local government and why new governing bodies must be created; I venture to suggest that the health services of Britain to-day have been largely created over the years by bodies having a reasonable size and sufficient autonomy to make them able to think and act speedily and effectively. As I said to you in 1946, we may find ourselves treading again these ways and returning to local government, that well tried organ of our political maturity.

This year’s health figures continue to be encouraging particularly those of our mothers and young children. The maternal mortality figure of the West Riding, once singled out as a blackspot, is now less than that for England and Wales and the number of children dying between the ages of 1 and 5 years fell to 191; infant mortality reached a new low level at 38. There seems to be a temporary check in our achievements in certain directions particularly against tuberculosis, syphilis, influenza, poliomyelitis, rheumatism and many of the diseases of middle and later years; yet in the light of present day research and with the development of modern services we should feel confident that a surge forward in these directions also cannot be far distant. It would therefore be wrong to regard the achievements of preventive medicine as more than at a beginning. We should aim for a community in which infant mortality, child mortality, maternal mortality, the problem family, tuberculosis, syphilis and all the afflictions of middle and later years are as far removed from our midst as are to-day cholera, typhus and plague.

I am,

Yours faithfully,

FRASER BROCKINGTON.

PART I

VITAL STATISTICS

Area (acres)—Urban, 380,334; Rural, 1,230,495—Total, 1,610,829

Population (mid. 1949)—Urban, 1,163,630; Rural, 413,870—Total, 1,577,500

Summary for 1949

The birth rate was 17.2; the still birth rate 24; the live premature birth rate 47. The death rate from all causes was 12.1; smallpox nil; scarlet fever 0.001; whooping cough and measles 0.01; diphtheria 0.003; zymotic diseases 0.08; tuberculosis of the lungs 0.32; other forms of tuberculosis 0.05; respiratory diseases 1.44; cancer 1.81; heart disease 3.71; diarrhoea in infants under 2 years 3.27. Infant mortality was 38 and maternal mortality 0.83.

A comparison with the figures for the past 60 years is given in the following table:—

Year	Birth Rate	Death Rate All Causes	Zymotic Death Rate	Tuberculosis of lungs Death Rate	Other Tuberculous Diseases Death Rate	Respiratory Diseases Death Rate	Cancer Death Rate	Still Births per 1,000 total births	Maternal Mortality per 1,000 live births	Infant Mortality
1890-1909	28.9	16.7	1.89	1.19	0.52*	3.20	0.77*	†	†	147
1910-1919	22.5	14.5	1.26	0.84	0.41	2.58	0.98	†	4.81	112
1920	25.1	12.6	0.94	0.71	0.28	2.26	1.07	†	5.26	92
1921	23.3	12.6	0.78	0.74	0.29	2.20	1.11	†	5.04	97
1922	20.9	12.2	0.58	0.68	0.30	2.07	1.15	†	4.16	81
1923	20.6	12.2	0.53	0.71	0.28	2.11	1.16	†	4.32	81
1924	20.4	12.8	0.48	0.70	0.25	2.43	1.19	†	4.57	83
1925	20.1	12.3	0.53	0.70	0.26	2.15	1.22	†	5.12	81
1926	19.4	11.6	0.46	0.62	0.22	1.78	1.24	†	4.82	73
1927	17.7	12.6	0.51	0.65	0.21	2.12	1.28	†	5.18	79
1928	17.7	11.5	0.28	0.61	0.22	1.46	1.29	†	5.45	62
1929	16.7	13.6	0.54	0.66	0.21	2.22	1.28	47	5.24	89
1930	16.9	11.4	0.33	0.57	0.20	1.35	1.33	45	6.25	65
1931	16.1	12.4	0.38	0.57	0.16	1.64	1.32	45	5.82	74
1932	15.8	12.1	0.39	0.52	0.17	1.33	1.46	48	5.22	70
1933	15.0	12.2	0.30	0.49	0.14	1.36	1.42	47	6.24	70
1934	15.2	11.7	0.41	0.44	0.12	1.16	1.44	48	5.81	58
1935	15.0	11.9	0.28	0.48	0.10	1.13	1.48	47	4.55	58
1936	15.1	12.3	0.29	0.44	0.12	1.25	1.51	45	4.35	63
1937	15.2	12.7	0.21	0.46	0.11	1.23	1.60	45	3.92	60
1938	15.5	11.6	0.23	0.38	0.11	0.99	1.55	44	3.74	51
1939	15.2	12.2	0.18	0.41	0.10	1.01	1.52	42	3.05	54
1940	15.3	13.4	0.18	0.42	0.11	1.94	1.58	40	3.26	56
1941	15.4	12.3	0.22	0.42	0.12	1.43	1.68	39	2.72	57
1942	17.0	11.7	0.18	0.42	0.12	1.26	1.65	36	3.36	49
1943	17.8	12.7	0.19	0.43	0.12	1.63	1.72	34	2.48	50
1944	20.2	12.1	0.12	0.37	0.09	1.32	1.79	31	1.98	44
1945	17.9	12.3	0.19	0.38	0.09	1.36	1.80	30	1.78	51
1946	19.7	11.9	0.13	0.36	0.08	1.31	1.72	29	1.86	44
1947	21.5	12.3	0.16	0.39	0.09	1.37	1.80	26	1.31	45
1948	18.5	11.3	0.12	0.37	0.07	1.29	1.74	24	1.17	39
1949	17.2	12.1	0.08	0.32	0.05	1.44	1.81	24	0.85	38

Birth and death rates are per 1,000 estimated population; the zymotic death rate is combined death rate from smallpox, scarlet fever, enteric fever, diphtheria, whooping cough, measles and diarrhoea in infants under 2 years of age (except the rate for 1890—1909 in which deaths from diarrhoea at all ages are included); the respiratory diseases death rate is the combined death rate from bronchitis, pneumonia and other respiratory diseases excluding tuberculosis of the lungs; the premature birth rate, the mortality rate for diarrhoea in infants and the infant mortality rate are per 1,000 live births. The maternal mortality rate is stated in two ways (a) per 1,000 live births (b) per 1,000 live and still births. The latter is obviously the more correct way but the number of still births has been available only since 1929, therefore the rates in the above table are per 1,000 live births in order that a correct statistical comparison is shown between the size of the rates since 1929 with those for previous years. The rate of 0.83 given in the Summary is per 1,000 live and still births, as is also the still birth rate.

* This rate is for the 10 years 1900—1909.

† Figures not available.

Population

In the latter part of 1949, the General Register Office published a report giving estimates of the sex and age distribution of the population in Regions and Administrative Areas of England and Wales at 31st December, 1947. It said "The only enumeration of local populations by sex and age since the Census of 1931, was that carried out for National Registration purposes on the 29th September, 1939, immediately after the outbreak of war. That enumeration was nominally confined to civilians but it was taken during a period of rapid mobilization and also of large scale evacuation from areas exposed to enemy attack. As a result, the record, while appropriate for the main purpose of serving as a base from which subsequent population changes could be traced and measured, represented a transitional state which, in many local areas, could not be regarded as reflecting more normal conditions, whether of the pre-war period or of today." As internal conditions have become more stable fairly accurate estimates can now be constructed, largely with the aid of the material available in the individual population records maintained in the local National Registration Offices; these should serve our main needs until the results of a fresh census are forthcoming. This has been done in the following table which shows the age constitution of the population of the West Riding Administrative County in 1931 and 1947.

Age Group	Population		Number per 1,000 total population	
	Census 1931	Estimated 1947	Census 1931	Estimated 1947
Under 5	117,587	132,680	78	86
5 and under 15	259,430	211,976	172	137
15 " " 20	127,652	92,492	85	60
20 " " 25	126,808	100,188	84	65
25 " " 35	244,609	229,431	163	148
35 " " 45	207,437	242,649	138	157
45 " " 55	184,806	209,632	123	136
55 " " 65	138,112	163,430	92	106
65 and over	97,616	161,932	65	105
Total	1,504,057	1,544,410	1,000	1,000

The proportion of "under fives" has increased from 78 to 86; the increase is due to the higher birth rate in 1947 and immediately preceding years, and it should be looked upon as a transitory phenomenon which will gradually disappear in the next six or seven years (if the downward trend in the birth rate which was evident in 1948 and 1949 continues). The outstanding feature of the table is the increase of persons aged 65 and over by 40 per thousand since 1931—that is in the comparatively short period of seventeen years.

The report of the Royal Commission on Population issued in 1949 (Cmd. 7695) commenting on the trend of population and the national interest points out that "The consequences of the trend of population are of various kinds: economic, social, psychological, political and strategic"; that "the problems arising out of past trend of population are very important"; and that "The increase that took place between 1891 and 1947 in the proportion of the working age groups relative to others was an appreciable factor in the rise of the standard of living over the last 70 years. This favourable influence will be reversed with the fall over the next 30 years in the proportion of the working ages. The fall will still leave the proportion well above the 19th century level, but account has to be taken of the rise since then in standards of consumption of dependents, young and old, in relation to those of the active population. Higher births in future would at first worsen the producer-consumer ratio, though ultimately it would slightly improve it. Between 1871 and 1947, the number of people over 65 in Great Britain increased four-fold, and the proportion rose from 4.8 per cent. to 10.4 per cent. The expected large increase in the number of the old makes it very desirable that we should make greater use of their productive capacity. There is good reason to hope that the standards of health and fitness at older ages will increase, and thus increase the numbers willing and able to continue at work. The increased rates of old age pensions combined with the condition that the pensions are payable only on retirement operate however against the increased employment of the old. The cost to the Exchequer of retirement pensions, making no allowance for any future fall in mortality, is estimated to increase from £238 millions in 1948 to £501 millions in 1978. With the increasing numbers of the old and consequently their increasing strength as a political pressure group, it is very important that the implications of proposals for increased pensions should be realised. A strong and sustained effort will be needed to meet the varied needs of the growing numbers of the old for accommodation and care."

Births and Infant Mortality

The number of live births in 1949 was 27,176 (17.2 per thousand) compared with 28,966 (18.5) in 1948 and 32,747 (21.5) in 1947. There were nearly 5,600 less births in 1949 than in 1947. In the six years immediately preceding the war the birth rate remained steady between the limits of 15.0 to 15.4. The rate increased during the war years, the peak of the increase being reached in 1947. Unless prevailing circumstances change considerably, the decline to a lower level which set in during 1948 and 1949 will probably continue, at any rate for a year or two, until comparative stability is reached.

Excess of births over deaths (natural increase of population) was 8,126 in 1949, 11,317 in 1948, 14,028 (1947), 9,308 (5 years 1942-46) and 4,536 (5 years 1937-41). The figures below show that the reduction in the infant mortality rate has appreciably offset the decline in the birth rate.

Period.	Birth rate.	Average annual number of births.	Average Annual number of deaths of infants under one year of age.	The addition to the population at end of one year.
1895-1904	29.4	42,677	6,510	36,167
1905-1914	25.6	39,301	4,840	34,461
1915-1924	21.1	31,748	3,018	28,730
1925-1934	17.1	26,195	1,896	24,299
1935-1944	16.1	24,126	1,303	22,823
1945	17.9	25,846	1,313	24,533
1946	19.7	29,577	1,304	28,273
1947	21.5	32,747	1,462	31,285
1948	18.5	28,966	1,129	27,837
1949	17.2	27,176	1,037	26,139

1,037 infants died, the rate being 38 compared with 39 in 1948 when a new low level was reached. In the five years preceding 1948 the rate varied between the limits of 44 to 50 and this level was low compared with that of the immediately previous years. The decrease to 38 in 1949 has been by no means gradual but has been reached by well marked decreases in particular years. Nearly 30 years ago the rate was about 95-100. It dropped to 81 in 1922, continued more or less on this level until 1930, when there was a drop to 65, then to 58 in 1933, 51 in 1938 and 44 in 1946. The effect of this decrease in infant mortality in terms of lives can be demonstrated by the figures below:—

Period.	Average Annual deaths if mortality had remained at level of 1912-21.	Actual Annual number of deaths.
1922-31	2,947	2,192
1932-41	2,402	1,388
1942-48	2,919	1,288
1949	2,815	1,037

The mortality of infants at various periods in the first year of life is shown below. The mortality among boys is always higher than among girls. This is a phenomenon which occurs generally and is not peculiar to the West Riding or the country as a whole.

	Number of Deaths					Deaths per 1,000 Live Births				
	1945	1946	1947	1948	1949	1945	1946	1947	1948	1949
<i>Male Infants</i>										
Under 4 weeks	407	455	450	339	323	30.3	29.6	26.7	22.9	23.1
4 weeks—3 months	130	124	147	112	94	9.7	8.1	8.7	7.6	6.7
3—6 months	116	104	130	99	94	8.6	6.8	7.7	6.7	6.7
6—12 months	107	75	117	80	73	7.9	4.9	7.0	5.4	5.2
Total under 1 year ...	760	758	844	630	584	56.5	49.4	50.1	42.6	41.7
<i>Female Infants</i>										
Under 4 weeks	273	317	353	266	259	22.0	22.2	22.2	18.8	19.7
4 weeks—3 months	76	82	82	84	68	6.1	5.8	5.1	5.9	5.2
3—6 months	103	82	103	85	61	8.3	5.8	6.5	6.0	4.6
6—12 months	101	65	80	64	65	8.2	4.6	5.0	4.5	4.9
Total under 1 year ...	553	546	618	499	453	44.6	38.4	38.8	35.2	34.4
<i>All Infants</i>										
Under 4 weeks	680	772	803	605	582	26.3	26.1	24.5	20.9	21.4
4 weeks—3 months	206	206	229	196	162	8.0	7.0	7.0	6.8	6.0
3—6 months	219	186	233	184	155	8.5	6.3	7.1	6.3	5.7
6—12 months	208	140	197	144	138	8.0	4.7	6.0	5.0	5.1
Total under 1 year ...	1313	1304	1462	1129	1037	50.8	44.1	44.6	39.0	38.2

Most of our infant deaths occur in the first month of life and it is here that our attack upon the problem of infant mortality must be made. Many of our schemes, e.g. to reduce the dangers of prematurity and illegitimacy have this object in view. The neonatal mortality declines slowly for the difficulties which have to be overcome are very great indeed. This year it actually increased slightly which may partly reflect the very large drop the year before; the rate for 1949 is appreciably lower than prior to 1948, particularly that for male infants (23.1 compared with 30.3 for 1945). On present knowledge we should be able to reduce the level of the neonatal mortality rate still further although it is approaching 20 per thousand births. As the Registrar-General states in his Statistical Review of England and Wales for the Six Years 1940-45 "The idea which was prevalent a decade ago that neonatal mortality was never likely to be reduced as a national figure

below about 20 per 1,000 births is no longer justifiable owing to advances in the treatment of immature infants and recent discoveries that haemolytic diseases and some forms of congenital malformations may be preventable. There seems no reason to postulate an irreducible hard core of neonatal mortality, nor of infant mortality generally, and any attempt to set "targets" for these is unprofitable."

The decline in the general infant mortality rate has taken place in relation to all causes of death though it has been more marked in relation to some causes than in others as will be seen from the table below:—

Year	Number of Deaths under One Year per 1000 live births from various causes																
	Infections													Con. Debility Malformations, Premature Birth	Other Causes	TOTAL (All Causes)	
	Enteric Fever	Smallpox	Scarlet Fever	Measles	Whooping Cough	Diphtheria	Influenza	Respiratory Tuberculosis	Other Tuberculous Diseases	Bronchitis	Pneumonia	Other Respiratory Diseases	Diarrhoea				Total
1912-21 (Average)	0.00	nil.	0.06	2.48	3.65	0.14	1.05	0.25	2.46	9.80	11.92	0.53	12.54	44.88	38.48	20.21	103.57
1922-31 (Average)	0.01	0.02	0.03	1.36	2.71	0.12	0.79	0.18	1.42	5.38	12.63	0.39	5.86	30.90	32.95	13.20	77.05
1932-41 (Average)	0.00	nil.	0.01	0.68	1.35	0.13	0.66	0.06	0.63	2.73	9.69	0.17	3.59	19.70	32.89	6.99	59.58
1942	nil.	nil.	nil.	0.32	0.64	0.08	0.08	0.12	0.40	1.88	7.47	0.12	3.91	15.02	28.32	5.63	48.97
1943	nil.	nil.	nil.	0.50	1.63	0.23	0.47	0.04	0.54	2.71	10.11	0.16	2.98	19.37	25.46	4.84	49.67
1944	nil.	nil.	nil.	0.07	0.48	nil.	0.03	0.10	0.31	2.12	7.64	0.21	2.76	13.72	25.93	4.71	44.36
1945	nil.	nil.	nil.	0.89	0.73	nil.	0.42	nil.	0.39	1.78	11.03	0.12	5.88	21.24	24.42	5.14	50.80
1946	nil.	nil.	nil.	0.07	0.91	0.03	0.30	0.03	0.24	0.91	7.68	0.10	4.06	14.33	25.63	4.13	44.09
1947	nil.	nil.	nil.	0.52	0.61	nil.	0.37	0.15	0.31	1.10	7.82	0.09	5.13	16.10	24.52	4.03	44.65
1948	nil.	nil.	nil.	0.24	0.83	0.03	0.28	0.03	0.35	1.00	7.84	0.28	4.25	15.13	20.76	3.11	38.99
1949	0.04	nil.	nil.	0.33	0.48	nil.	0.11	0.04	0.59	1.18	7.03	0.07	3.16	13.03	21.27	3.86	38.16

* From the year 1942 it is possible to give the infant mortality rate from premature birth separately; the figures are:—1942, 13.54; 1943, 13.41; 1944, 12.35; 1945, 11.30; 1946, 12.78; 1947, 11.51; 1948, 9.36; and 1949, 8.39.

One of the striking changes is the reduction in deaths from infantile diarrhoea; thirty or forty years ago a dry, hot summer, such as we had in 1949, would have been sufficient to cause an increase in the infant mortality rate of 20 to 30 per thousand. Thus in 1911 the infant mortality rate rose by 26 per thousand. Last year a similar year there was no such increase; the infant mortality rate from diarrhoea and enteritis was 3.16 as compared with 37 in 1911. This great change although encouraging does not provide any reason for complacency; mortality from diarrhoea and enteritis should be reduced to negligible proportions. As a further step forward the Hospital for Sick Children, Great Ormond Street, London, has set up a specialised team of doctor and nurses known as a Flying Squad, available to give assistance in hospitals and institutions where proper facilities for dealing with outbreaks of infantile gastro-enteritis do not exist. Through our divisional scheme the matter is receiving the closest attention. A gastro-enteritis unit might be established eventually in the West Riding, to which cases might be admitted from any source and from which a Flying Squad might operate.

The infant mortality rates for the past five quinquennial periods have been 77, 66, 57, 51 and 43 in Urban Districts and 76, 70, 57, 51 and 45 in Rural Districts. The highest rates in 1949 were Adwick-le-Street U.D. (66), Darfield U.D. (63), Heckmondwike U.D. (75), Hemsworth U.D. (60), Maltby U.D. (71), Selby U.D. (72), Silsden U.D. (67), Wath-upon-Deane U.D. (60), Sedbergh R.D. (64) and Thorne R.D. (61); the lowest, Aireborough U.D. (16), Baildon U.D. (8), Bingley U.D. (13), Denholme U.D. (nil), Hebden Royd U.D. (14), Meltham U.D. (nil), Otley U.D. (16), Penistone U.D. (nil), Ripponden U.D. (nil), Selby R.D. (9) and Skipton R.D. (17). The small number of births in individual districts makes comparison between the rates of different County Districts difficult. A somewhat rough idea of the decline of infant mortality in the County Districts can be gained from the following figures:—

Period.	Percentage of Districts with an infant mortality rate of:			
	Under 25.	25 to 50.	50 to 75.	75 and over.
1897-1906	1.7	2.4	7.3	88.6
1949	23.6	58.4	18.0	—

Illegitimacy is of profound significance to the health of the community which fundamentally depends upon the healthy family. The illegitimate birth rate is still alarmingly high and continues a grave danger to community health. The birth of approximately 1,300 to 1,400 such babies annually in the Administrative County creates a social problem which should not be overlooked. One favourable feature is the tendency, however slight, for the ratio of illegitimate live births to legitimate live births to decline. Another is the continued success in saving the lives of illegitimate infants and the mortality this year fell to its lowest level at 50 per 1,000 live births. The figures for the past eleven years are shown on the following page.

Year.	Number of illegitimate live births	Percentage ratio to legitimate live births	Number of deaths under 1 year of illegitimate infants	Infant Mortality Rate.	
				Illegitimate infants	Legitimate infants
1939	834	3.79	53	64	54
1940	827	3.77	68	82	55
1941	1,044	4.71	86	82	58
1942	1,181	4.95	72	61	48
1943	1,381	5.65	88	64	49
1944	1,720	6.24	107	62	43
1945	1,892	7.90	133	70	49
1946	1,739	6.25	112	64	43
1947	1,525	4.88	99	65	44
1948	1,413	5.13	72	51	38
Average for 10 years 1939-48	1,356	5.37	89	66	48
1949	1,323	5.12	66	50	38

Deaths

The deaths from all causes in 1949 numbered 19,050 (9,873 males, 9,177 females), an increase of 1,401 on the number in 1948, and yielding a death rate per thousand of the estimated population of 12.1 (11.7 England and Wales) as compared with 11.3 (10.8 England and Wales). The increase did not take place in the West Riding alone, but was experienced by the country as a whole. The increase affected every age group excepting that in the West Riding there was a decrease for children under 5 years of age and infants. The increase was spread over most causes of death with a few minor exceptions, and was not due to an exceptional increase in mortality from any particular cause.

The table below shows the number of deaths and causes for 1949:—

CAUSE OF DEATH		AGE AT DEATH						Total
		Under 1 year	1 and under 5	5 and under 15	15 and under 45	45 and under 65	65 and over	
1.	Typhoid and paratyphoid fevers ...	1	—	—	—	—	—	1
2.	Cerebro-spinal fever	4	2	2	5	1	1	15
3.	Scarlet fever	—	—	—	—	—	1	1
4.	Whooping cough	13	4	1	—	—	—	18
5.	Diphtheria	—	3	1	1	—	—	5
6.	Tuberculosis of respiratory system ...	1	2	3	235	190	67	498
7.	Other forms of tuberculosis	16	24	9	17	15	5	86
8.	Syphilitic diseases	5	1	—	3	30	31	70
9.	Influenza	3	4	3	15	49	153	227
10.	Measles	9	6	2	—	—	1	18
11.	Acute poliomyelitis and polio enceph.	1	4	10	10	2	1	28
12.	Acute infectious encephalitis	—	—	—	3	2	5	10
13. (a)	Cancer of buc. cav. and oesoph (males)	—	—	—	2	21	74	97
13. (b)	Cancer of uterus (females)	—	—	—	25	82	69	176
14.	Cancer of stomach and duodenum ...	—	—	—	22	210	351	583
15.	Cancer of breast	—	—	—	33	104	105	242
16.	Cancer of all other sites	1	5	6	127	624	988	1751
	<i>Total—All Forms of Cancer</i>	1	5	6	209	1041	1587	2849
17.	Diabetes	—	—	—	4	33	108	145
18.	Intracranial vascular lesions	—	1	—	25	418	1923	2367
19.	Heart diseases	—	2	10	170	1185	4484	5851
20.	Other diseases of circ. system	1	—	—	17	109	624	751
21.	Bronchitis	32	7	2	37	342	912	1332
22.	Pneumonia	191	39	7	43	114	285	679
23.	Other respiratory diseases	2	4	1	26	95	131	259
24.	Ulcer of stomach or duodenum	—	—	—	21	79	56	156
25.	Diarrhoea under 2 years	86	3	—	—	—	—	89
26.	Appendicitis	—	3	4	7	8	12	34
27.	Other digestive diseases	8	7	10	34	96	169	324
28.	Nephritis	1	—	6	58	128	270	463
29.	Puerperal and post-abortive sepsis ...	—	—	—	4	—	—	4
30.	Other maternal causes	—	—	—	19	—	—	19
31.	Premature birth	228	—	—	—	—	—	228
32.	Congen. mal., birth inj., infant diseases	350	15	12	12	11	3	403
33.	Suicide	—	—	—	31	72	37	140
34.	Road traffic accidents	2	12	26	76	30	28	174
35.	Other violent causes	43	25	24	89	97	162	440
36.	All other causes	39	18	27	125	249	908	1366
TOTAL—ALL CAUSES ...		1037	191	166	1296	4396	11964	19050

Child Mortality

The considerable rate of decrease in the death rate of children in the age group 1—5 years in the West Riding was commented upon in my report for 1948. The decrease has continued in 1949. The rate for 1949 is 31 per cent. of that for 1935 and 29 per cent. of that for 1936. The rates for the past 15 years are given below:—

Deaths of children aged 1—5 years per 1,000 living in that age group.

Year.	West Riding.	England and Wales.
1935	5.44	5.08
1936	5.78	5.50
1937	5.28	5.11
1938	4.89	4.59
1939	4.04	3.49
1940	4.74	4.83
1941	4.93	5.30
1942	4.35	3.42
1943	4.05	3.34
1944	2.76	2.71
1945	3.08	2.64
1946	2.19	2.08
1947	2.44	2.18
1948	2.07	1.75
1949	1.70	1.56

The number of deaths of children aged 1—5 years from the various causes in the past 15 years is shown in the table below:—

	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948	1949
Scarlet Fever	19	16	8	8	7	3	3	—	3	2	—	—	—	—	—
Typhoid and Paratyphoid Fevers	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—
Diphtheria	62	57	49	43	41	40	40	37	24	19	10	6	—	4	3
Encephalitis Lethargica	—	2	—	—	2	—	—	—	—	—	—	—	—	—	—
Cerebro-spinal Fever	9	4	6	4	3	11	18	6	6	9	4	3	9	6	2
Poliomyelitis and poli-encephalitis	1	2	—	3	—	1	—	—	—	2	—	—	5	1	4
Syphilitic diseases	1	—	—	—	—	1	—	—	—	—	—	—	—	1	1
Influenza	9	7	17	6	9	27	5	8	12	5	3	7	4	1	4
Whooping Cough	24	39	34	12	37	10	44	15	25	6	12	13	16	8	4
Measles	17	50	17	48	4	24	18	19	27	2	22	2	16	6	6
Bronchitis	9	14	11	10	7	25	21	14	17	7	11	7	11	9	7
Pneumonia	130	136	141	114	82	111	94	82	80	56	56	40	36	40	39
Other respiratory diseases	11	6	4	3	5	2	7	4	7	4	4	2	1	6	4
Respiratory tuberculosis	9	7	6	3	2	4	4	4	2	5	8	1	2	7	2
Other forms of tuberculosis	38	39	36	32	41	37	39	48	44	25	33	20	42	28	24
Heart and circulatory diseases	2	4	3	1	2	—	2	2	—	1	2	1	—	2	2
Diarrhoea and other digestive diseases	46	37	41	38	28	19	17	31	28	22	21	18	16	18	13
Nephritis	4	3	5	1	2	1	3	2	5	2	4	4	3	—	—
Diabetes	—	—	2	—	—	—	1	—	—	1	—	—	—	—	—
Cancer	5	5	2	4	2	2	7	7	6	8	3	4	6	3	5
Congenital debility, malformations, premature birth, etc.	8	6	4	9	10	12	14	9	4	12	8	16	8	14	15
Violence	49	50	57	50	41	32	41	47	32	19	36	16	25	18	25
Road Traffic Accidents	—	—	—	—	—	12	14	21	10	9	16	15	11	13	12
Other Causes	53	50	41	56	40	54	53	36	33	32	39	28	31	21	19
Totals	506	534	484	445	365	428	445	392	365	248	292	204	242	206	191

The number of deaths in 1949 was 315 less than the figure for 1935. This decrease took place chiefly in deaths from infectious diseases (from 132 in 1935 to 17 in 1949), pneumonia (130 to 39), tuberculosis (47 to 26), diarrhoea and other digestive diseases (46 to 13). The only group of causes showing a definite increase in deaths is that of congenital debility, etc. (8 to 15). Deaths from road traffic accidents have been shown separately since 1940 in which year, as also in 1949, there were 12 deaths in children aged 1—5 years. Of the 191 total deaths (out of approximately 112,000 children) in 1949, pneumonia accounted for 21 per cent., violence, including road traffic accidents, for 19 per cent. and non-respiratory tuberculosis 12 per cent.

Maternal Mortality

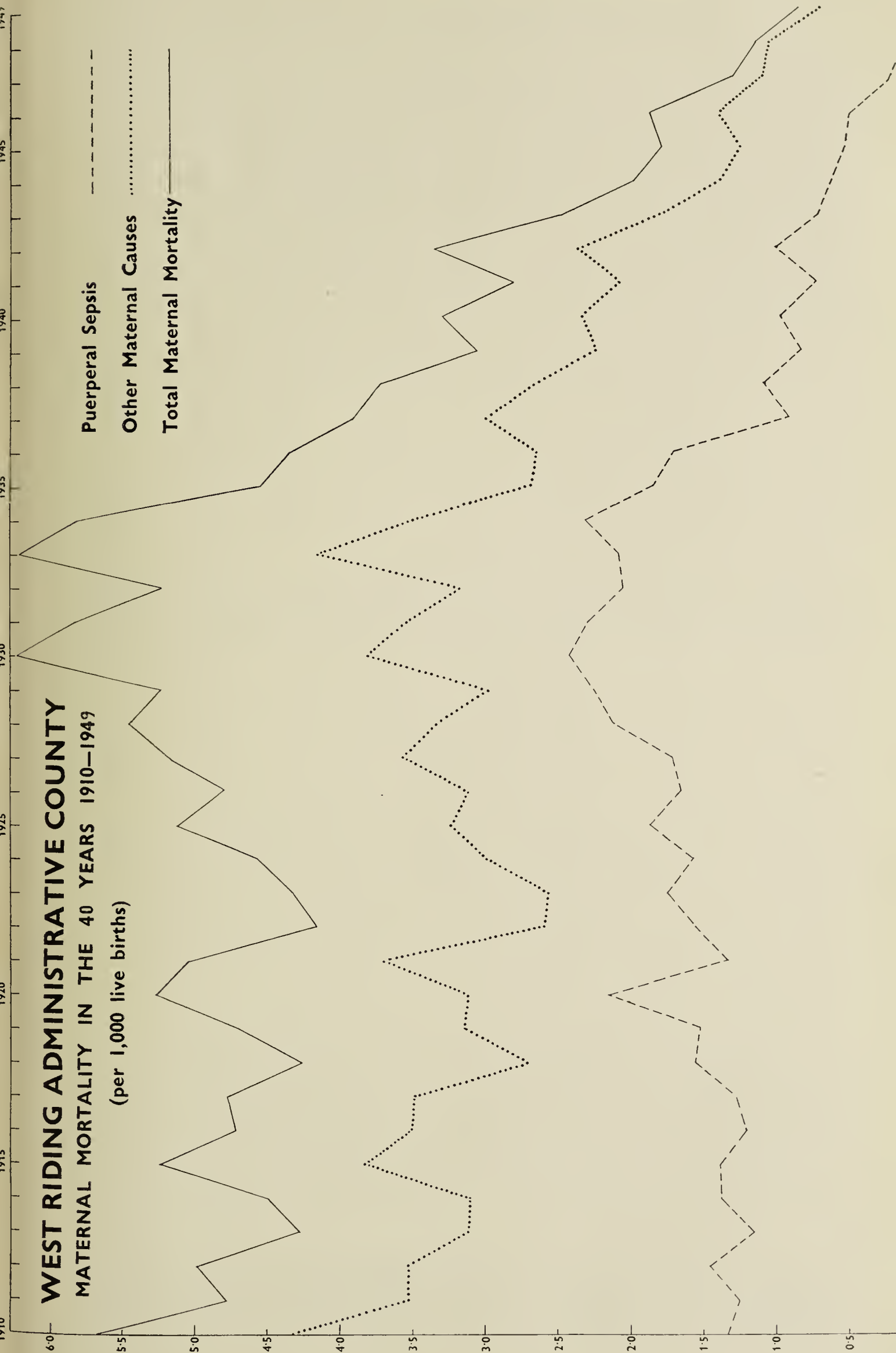
In his Annual Report for 1928, the Chief Medical Officer of the Ministry of Health included the West Riding in a black-list of Administrative Counties and County Boroughs which had the highest maternal mortality rates. The high rates in the West Riding and Lancashire with their associated County Boroughs, and in certain parts of Wales, were specially investigated in 1931 by Medical Officers of the Ministry, whose report was published in 1932 ("High Maternal Mortality in Certain Areas"—Ministry of Health Reports on Public Health and Medical Subjects, No. 68). Comment on the high rate in these areas was also made in the final report of the Departmental Committee on Maternal Mortality and Morbidity. Since then, there has been a remarkable, if not spectacular, improvement in the West Riding Administrative County. In the years immediately prior to 1933, when the maternal mortality rate was 5.94, the trend appeared to be towards increase. Since 1933, however, the rate has steadily declined to 0.83 in 1949. This is below the corresponding rate for England and Wales (0.98). The number of maternal deaths and the mortality rate in the Administrative County in the past 21 years are shown below:—

Year	No. of deaths from			Mortality Rate per 1,000 live and still births		
	Puerperal and post abortive sepsis	Other maternal causes	Total	Puerperal and post abortive sepsis	Other maternal causes	Total
1929	58	76	134	2.16	2.83	4.99
1930	63	99	162	2.32	3.64	5.96
1931	57	88	145	2.19	3.37	5.56
1932	50	77	127	1.96	3.01	4.97
1933	48	96	144	1.98	3.96	5.94
1934	54	82	136	2.20	3.33	5.53
1935	43	62	105	1.78	2.56	4.34
1936	39	61	100	1.62	2.54	4.16
1937	21	69	90	0.87	2.87	3.74
1938	25	62	87	1.03	2.55	3.58
1939	19	51	70	0.79	2.13	2.92
1940	22	53	75	0.92	2.21	3.13
1941	17	48	65	0.68	1.93	2.61
1942	25	59	84	0.96	2.27	3.23
1943	18	46	64	0.68	1.72	2.40
1944	18	40	58	0.60	1.32	1.92
1945	14	32	46	0.53	1.20	1.73
1946	14	41	55	0.46	1.34	1.80
1947	7	36	43	0.21	1.07	1.28
1948	3	31	34	0.10	1.05	1.15
1949	4	19	23	0.15	0.68	0.83

The trend of the rate is shown graphically opposite.

WEST RIDING ADMINISTRATIVE COUNTY **MATERNAL MORTALITY IN THE 40 YEARS 1910-1949** (per 1,000 live births)

Puerperal Sepsis - - - - -
Other Maternal Causes
Total Maternal Mortality —————



The Mortality of the Middle and Later Years of Life

The increasing proportion of older persons in the age constitution of the population will focus attention more and more on the diseases of middle and old age. To give an example, the increase in the proportion of persons in the population in the middle and later age groups together with the increased stress and intensity in the rate of living in the twentieth century among most persons has contributed to increase the death rate from heart and circulatory diseases. In the West Riding the death rate from this group of diseases has increased in the last twenty years from 308 to 419 per 100,000 of the population. The mortality from cancer has similarly increased from 132 to 181 and (in ten years) cerebral haemorrhage and associated causes from 145 to 150, moreover the mortality from all these causes is rising steadily. Health education, medical research, adequate diagnostic facilities and facilities for early treatment, particularly in the case of cancer, must all play their part in checking at least the increase in mortality from these causes.

The number of deaths and death rates per 100,000, according to age, from these diseases in the three years 1947 to 1949 are shown below, and emphasise their killing nature in the middle and later age groups.

		AGE GROUP — YEARS					
		Under 5	5 to 15	15 to 45	45 to 65	65 up	All Ages
Cancer	Deaths	19	15	596	3,128	4,548	8,306
	Rate	5	2	30	279	936	178
Cerebral Haemorrhage	Deaths	6	—	79	1,348	5,329	6,762
	Rate	2	—	4	120	1,097	145
Heart and circulatory diseases	Deaths	5	34	613	3,679	14,168	18,499
	Rate	1	5	31	329	2,916	396

Coronary Thrombosis (a disease of the arterics supplying nourishment to the heart muscle) will probably assume increasing importance as a result of the factors previously mentioned. The following table shows the number of deaths in 1949 in the Administrative County, according to age and social class, where coronary thrombosis is given as chief or associated cause of death.

Age Group	Social Class													
	Males							Females						
	I	II	III	IV	V	Total	Death Rate per 1,000	I	II	III	IV	V	Total	Death Rate per 1,000
Years														
35—45	1	9	10	5	2	27	0·22	—	2	3	—	—	5	0·04
45—55	6	26	46	19	11	108	1·09	1	5	10	6	3	25	0·23
55—65	15	61	120	46	32	274	3·64	5	13	46	19	7	90	1·02
65—75	19	83	163	50	41	356	6·87	11	58	104	33	18	224	3·55
75 and over	11	53	99	23	18	204	10·49	6	45	67	24	11	153	5·55
Total all ages	52	232	438	143	104	969	2·64	23	123	230	82	39	497	1·21
Rate per 1,000 in social class	11·9	6·1	3·0	1·8	2·9			6·3	3·2	1·2	1·1	1·2		

No recent statistics are available as to the population in the different social classes and the above rates are based on the 1931 Census figures. These rates, therefore, should not be taken as absolutely accurate death rates, but they must give a fairly definite idea of the relative mortality in the several social classes. The deaths of housewives have been classed according to the social class of their husband, also for the purpose of arriving at the population of females in each social class, for calculation of the death rates according to social class, housewives have been allocated over the five social classes proportionately to the number of males in each social class. The death rates according to age can be taken as definite rates. The social class divisions used in the table are the classifications of the Registrar-General on which statistics relating to social class are usually based.

The Registrar-General states that Class I of the Social Classes “purports to represent the professional and generally well-to-do section of the population, Class III, Skilled artizan and analogous workers and Class V, Labourers and other unskilled callings, while Classes II and IV are intermediates comprising occupations of mixed types, or types not readily assignable to the classes on either side.”

PART II

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease

Smallpox, cholera, diphtheria, membranous croup, erysipelas, scarlet fever, and the fevers known by any of the following names, typhus, typhoid, enteric or relapsing, are compulsorily notifiable under Section 144 of the Public Health Act, 1936; chickenpox is notifiable under Section 147 of the same Act in some West Riding County Districts; food poisoning under Section 17 of the Food and Drugs Act, 1938. The following communicable diseases are compulsorily notifiable under the regulations stated in brackets—measles and whooping cough (Measles and Whooping Cough Regulations, 1940); cerebro-spinal fever and acute poliomyelitis (Cerebro-Spinal Fever and Acute Poliomyelitis Regulations, 1912); acute encephalitis lethargica and acute polio-encephalitis (Acute Encephalitis Lethargica and Polio-encephalitis Regulations 1918 and 1919)*; ophthalmia neonatorum (Ophthalmia Neonatorum Regulations, 1926, 1928 and 1937); puerperal pyrexia (Puerperal Pyrexia Regulations, 1937); tuberculosis (Tuberculosis Regulations, 1930); malaria, dysentery and acute primary and influenzal pneumonia (Infectious Diseases Regulations, 1927); plague (Notification of Case of Plague (General) Regulations, 1900). The contagious diseases of syphilis, gonorrhoea and soft chancre (classed under the term venereal diseases) and scabies are not compulsorily notifiable.*

The following table shows the number of cases in 1949 of each "notifiable" disease, being the numbers of cases originally notified and the final numbers after corrections subsequently made by the notifying medical practitioner or by the Medical Superintendent of the infectious diseases hospital:—

AGE GROUP	Scarlet Fever		Whooping Cough		Acute Poliomyelitis		Acute Polio-encephalitis		Measles		Diphtheria	
	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified (All Ages)	1491	1742	1859	2094	153	139	16	10	8353	8136	70	86
	3233		3953		292		26		16489		156	
Final numbers after correction												
0— ...	1	2	159	167	6	8	1	1	344	378	1	—
1— ...	167	160	541	626	21	17	4	1	2189	2092	5	2
3— ...	376	386	559	617	13	15	3	2	2691	2601	4	4
5— ...	682	818	553	588	32	30	2	4	2800	2702	10	10
10— ...	149	246	33	54	17	12	—	2	189	197	5	6
15— ...	64	63	3	12	20	10	2	1	54	56	1	6
25 and over ...	27	42	6	22	10	13	3	—	53	81	5	6
Age unknown	6	2	4	3	—	—	—	—	34	28	1	—
Totals all ages	1472	1719	1858	2089	119	105	15	11	8354	8135	32	34
	3191		3947		224		26		16489		66	
AGE GROUP	Acute Pneumonia		Dysentery		Typhoid and Paratyphoid Fever		Erysipelas		Cerebro-Spinal Fever		Food Poisoning	
	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified (All Ages)	819	640	45	29	15	5	190	240	46	38	342	354
	1459		74		20		430		84		696	
Final numbers after correction												
0— ...	167	137	17	9	—	1	1	4	9	7	26	12
5— ...	114	86	10	6	6	—	7	1	11	8	17	13
15— ...	221	139	15	5	3	3	58	73	10	6	40	44
45— ...	190	147	—	2	1	—	90	114	4	1	37	26
65 and over ...	120	125	—	1	—	—	30	46	—	3	5	9
Age unknown	7	3	3	5	—	—	4	1	—	1	28	72
Totals all ages	819	637	45	28	10	4	190	239	34	26	153	176
	1456		73		14		429		60		329	

Number Originally
Notified

Number After
Correction

Puerperal Pyrexia ...	105	98
Ophthalmia Neonatorum ...	40	37
Chicken Pox ...	827	† not corrected

† Chicken pox is compulsorily notifiable only in certain County Districts.

* These Regulations have been replaced by the Public Health (Acute Poliomyelitis, Acute Encephalitis, and Meningococcal Infection) Regulations, 1949, which came into force on the 1st January, 1950. These new Regulations introduce nomenclature consistent with the International Standard Classification of Diseases which were brought into general use on 1st January, 1950, and slightly extend the scope of clinical conditions notifiable under the head of acute encephalitis.

The table below affords a comparison with the preceding four years:—

Disease				1945	1946	1947	1948	1949
				—	—	—	—	—
Scarlet Fever	...	...	...	3,109	2,369	2,764	3,863	3,191
Whooping Cough	...	...	...	2,844	4,451	3,424	6,201	3,947
Diphtheria	...	...	...	862	551	221	153	66
Measles	...	...	...	24,904	1,883	21,739	16,545	16,489
Acute Pneumonia (primary or influenzal)				1,347	1,324	1,188	1,308	1,456
Cerebro-Spinal Fever	...	...	...	67	71	78	56	60
Acute Poliomyelitis	...	...	...	7	1	351	46	224
Acute Polioencephalitis	...	...	...	1	—	49	6	26
Acute Encephalitis Lethargica	...	...	...	3	2	2	1	2
Dysentery	...	...	...	411	127	108	208	73
Ophthalmia Neonatorum	...	...	...	46	46	82	51	37
Puerperal Pyrexia	...	...	...	81	104	85	98	98
Smallpox	...	...	...	—	—	—	—	—
Enteric or Typhoid Fever (excluding Paratyphoid)	...	...	...	9	14	9	18	3
Paratyphoid Fevers	...	...	...	7	50	16	10	11
Erysipelas	...	...	...	383	366	347	409	429
Chicken Pox	...	...	...	310	443	550	432	827
Typhus Fever	...	...	...	1	—	—	—	—
Malaria	...	...	...	36	28	11	6	2
Tuberculosis:—								
Respiratory	...	...	...	1,229	1,244	1,288	1,372	1,526
Other Forms	...	...	...	457	437	400	424	456
Total	...	...	...	1,686	1,681	1,688	1,796	1,982

The increased prevalence of scarlet fever and whooping cough in 1948 died down in 1949; compared with the previous four years, the incidence of diphtheria and dysentery decreased considerably and that of measles slightly. There were more cases of acute pneumonia, poliomyelitis, chicken pox and tuberculosis than last year. 357 books were disinfected in 1949 for the County Library.

Food Poisoning

Section 17(1) of the Food and Drugs Act, 1938, provides that if a medical practitioner becomes aware, or suspects, that a patient whom he is attending within the district of any Local Authority is suffering from food poisoning, he shall forthwith send particulars of the case to the Medical Officer of Health of that district. Food poisoning is not defined in the Food and Drugs Act, 1938; it would be difficult to define it, as the symptoms can be so similar to those of the commencing stages of other diseases. The main object of Section 17 is to ensure that the Medical Officer of Health is informed of suspected outbreaks to enable him to make the necessary investigation without delay, and to bring to his notice circumstances requiring further investigation which may be of importance to the spread of disease and the protection of community health. The increase in the incidence of suspected outbreaks is related to the preparation of food in bulk and communal feeding both of which have become more prevalent.

The following is a statistical summary of cases and outbreaks in 1949. Although the figures are given on a Divisional basis, it should be understood that the cases would be investigated by the Medical Officer in his capacity as Medical Officer of Health and not as Divisional Medical Officer.

Return of Food Poisoning Notifications—Year 1949

Division No.	Food Poisoning Notifications returned to R.G. (Corrected).					Number of outbreaks due to Identified Agents.						Outbreaks of Undiscovered Cause		Single Cases		
	Quarter of year				Total	Chemical Poisons	Salmonella Organisms	Staphylococci (inc. Toxin)	Cl. botulinum	Other bacteria	Cases	No. of outbreaks	No. of Cases	Agent Identified	Unknown Cause	Total
	1st	2nd	3rd	4th												
1	—	—	27	—	27	—	1	—	—	—	27	—	—	—	—	—
2	—	—	—	—	—	—	1	—	—	—	332	1	11	1	—	1
3	—	1	*12	1	*14	—	2	—	—	—	*10	—	—	2	2	4
4	—	—	1	—	1	—	—	—	—	—	—	—	—	1	—	1
5	—	—	1	—	1	—	—	—	—	—	—	—	—	1	—	1
6	6	12	50	19	87	—	1	—	—	1	240	2	23	1	71	72
7	—	1	—	—	1	—	—	—	—	—	—	—	—	—	1	1
8	1	3	1	—	5	—	—	—	—	—	—	—	—	2	3	5
9	—	8	1	—	9	—	—	1	—	—	7	—	—	1	1	2
10	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
11	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
12	—	1	—	—	1	—	—	—	—	—	—	—	—	1	—	1
13	—	12	—	—	12	—	—	1	—	—	25	—	—	—	—	—
14	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
15	—	2	32	29	63	—	—	—	—	—	—	2	61	—	2	2
16	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
17	—	—	3	—	3	—	—	1	—	—	3	—	—	—	—	—
18	—	—	—	15	15	—	—	1	—	—	15	—	—	—	—	—
19	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
20	—	2	—	—	2	—	—	—	—	—	—	—	—	—	2	2
21	—	8	—	—	8	—	1	—	—	—	4	1	4	—	—	—
22	2	2	—	3	7	—	—	—	—	—	—	—	—	—	7	7
23	—	30	17	—	47	—	—	2	—	—	47	—	—	—	—	—
24	—	—	2	—	2	—	—	—	—	—	—	—	—	—	2	2
25	—	2	1	—	3	—	—	—	—	—	—	—	—	1	2	3
26	—	1	—	—	1	—	—	—	—	—	—	1	23	1	—	1
27	—	—	5	1	6	—	—	—	—	—	—	1	4	—	2	2
28	—	1	2	—	3	—	—	—	—	—	—	1	2	1	—	1
29	—	—	—	1	1	—	—	—	—	—	—	—	—	1	—	1
30	—	—	—	1	1	—	—	—	—	—	—	—	—	1	—	1
31	—	—	6	3	9	—	—	—	—	—	—	2	4	—	5	5
Total	9	86	161	73	329	—	5	6	—	1	704	11	132	15	98	113

* Includes 6 cases arising from consumption of ice-cream in a district outside No. 3 Divisional Area.

The Divisional Medical Officers and County Sanitary Inspectors, working in co-operation, made 14 investigations at schools and school canteens of suspected food poisoning among scholars and staffs following consumption of food supplied under the school meals scheme. Specimens of food and faeces were examined bacteriologically in appropriate cases but no pathogenic organisms of the food poisoning group were isolated.

In co-operation with the Public Health Laboratory and the Education Committee, a limited investigation was made into the bacteriological condition of crockery and utensils at schools, used for school meals, after washing by ordinary methods and after the introduction of a routine using a liquid detergent and hypochlorite solution. This was carried out at 4 schools, two with heated rinsing sinks and two with wash-up sinks only, during October, 1949.

The experiment showed that:—

- 64% of the crockery and utensils washed by the ordinary methods in use was unsatisfactory,
- the condition of food containers was not improved by sealding,
- the efficiency of the ordinary methods appeared to depend on the efficiency of the staffs and the use of heated rinsing sinks,
- the use of heated rinsing sinks under proper supervision should give satisfactory results,
- the introduction of a detergent and hypochlorite routine resulted in consistently low bacterial counts with no unsatisfactory results, whether rinsing sinks or single sinks only were used, and
- that the use of this detergent and hypochlorite routine would appear to give consistently satisfactory results even with limited washing-up facilities and staffs of varying ability.

As a result of these conclusions it was decided that an experiment on a larger scale should be carried out during 1950.

Diphtheria

Only 66 confirmed cases of diphtheria occurred last year and there seems reason to hope that the disease will soon be conquered entirely. This makes it necessary to examine closely our immunisation policy, since it must be assumed that continued immunity can only be enjoyed within a highly immune population. If we neglect immunisation, and there is a danger that freedom from the disease will engender apathy, then there will be a risk of serious recrudescence. The number of children who completed a full course of primary immunisation during the year, either through their own private medical practitioners or at the Authority's clinics or schools, was 27,890 (under 5 years 20,728; 5 to 15 years 7,162). In addition 18,071 children received refresher injections.

Although a comparatively large number of children are still coming forward each year for immunisation we are still far short of achieving the aim of 75% immunisation of all children reaching the age of one year. The usually accepted method of campaign of issuing posters, placing advertisements in the local press, distributing leaflets to parents drawing attention to the wisdom of early immunisation against diphtheria, no longer produces the desired results and special immunisation clinics are generally only sparsely attended. With the decline in recent years of the incidence of diphtheria, parents on the whole are adopting a casual attitude towards immunisation and it is clear that there is need for a different approach to the problem if this apparent apathy on the part of the parents is to be overcome.

One example of what can be done was admirably illustrated in a campaign organised during the summer of 1949 by Dr. Paterson, Divisional Medical Officer of the Castleford and Normanton area. The following is an extract from Dr. Paterson's report:—

"The success of our immunisation programme in the past, has depended on how far we have been able to popularise our static immunisation clinics, either as part of our Maternity and Child Welfare Service, or as an integral part of the School Medical Service. Provided we can once enlist an intelligent interest on the part of our Health Visitors and other nursing staff, as a very necessary addition to the multiplicity of interests they are already expected to shoulder, and provided we can sustain that interest during the daily routine, then we can say that more than half the battle has been won. Ready co-operation on the part of the parents in an effort of this sort is also a very vital necessity. The better immunisation results obtained in the 5—15 age group can undoubtedly be attributed to two important contributory factors, the one, and to my mind the more important one, depends on the fact that once having given consent, the parent can take a completely impersonal view of any further proceedings, since the actual immunisation takes place in school where her attendance is not required and the other is the psychological effect on the child of not wanting to be the odd man out amongst so many others. Success also depends on the avoidance, as far as possible, of widespread reactions by the use of appropriate antigens, and it is no exaggeration to say that one really bad reaction in a school can do untold harm in militating against what otherwise would be a most successful run of immunisations. Obviously, owing to the lower immunisation percentage obtained, the same set of factors cannot operate in the case of the 0—4 age group and one can readily imagine the amount of moral courage the mother must pluck up before she can bring her child to be immunised, either in her own presence or in an adjacent room. The fact that she does come forward and readily so is striking testimony to the faith she has in the efficacy of immunisation against diphtheria, but it is just as true to say that a certain section of the mothers in this age group cannot, because of domestic ties, etc., or will not, bring their children to be immunised at the static clinic and a means must be found sooner or later, if we are to be completely successful in our efforts, to bring them inside our net. One very practical way of meeting and overcoming this problem has been found to be by the institution of a mobile immunisation unit which will take immunisation to the very doors of the children and in this way shatter the very last vestige of an excuse that these parents may have against the immunisation of their children. This method is not entirely novel since it has been in operation in several County Boroughs and at least in one County Council for a number of years now, but it has not yet attained universal popularity. In view of its flexibility and extreme adaptability it was decided to operate a pilot service of this type in Division II of the West Riding to test its suitability in this area, and the very favourable results obtained during its trial run merit particular consideration with a view to its continuance. During the four Fridays of August, 1949, a first visit was paid to areas of the constituent districts comprising this Division, and a second visit was paid in the four Fridays of September, to complete the second injections. In all, 16 sessions were carried out, and it was found that a total of 1,116 injections were given, working out at 70 injections being given per session. Furthermore, in the light of experience gained during this pilot survey, it was found that provided the details had been properly worked out beforehand, a total of 80 injections per session could be attained without undue strain on the personnel. It will be seen that this number compares very favourably with the work as is carried out at a static immunisation clinic, where it is, I think, generally agreed that 20 per session is considered about the average. Such a static clinic will immobilise a doctor and two nurses, whereas the mobile immunisation clinic will immobilise a doctor and five nurses, and the latter system, whereby four times the number of children can be immunised, quite apart from effecting a very considerable saving in the doctor's time, also sets free three nurses to do other work. This, I think, demonstrated quite clearly that far from being an economically unsound proposition, the mobile unit can be used to a very great advantage and need not clash in any way with the more conventional static clinics, being essentially auxiliary to them. The success of this pilot survey was not in any way fortuitous but the result of a carefully planned scheme where emphasis laid on details was found to count for a lot in contributing to the final figures. Of prime importance is the size of the van where the immunisations are carried out, and this must be in all respects

adequate to allow the work to be carried out unhampered and with sufficient "elbow room." One of the larger types of ambulance with an additional door at the cab end to allow of one way traffic would serve as a temporary measure but I do feel that eventually a more roomy type of vehicle, perhaps one after the style of the mobile dental van, would be found to be much more desirable. It was shown very conclusively during the experimental run that if the working space available was cramped and inadequate, frustration and irritation at once ensued. Next in order of importance is the provision of a sufficiency of personnel to feed and keep the unit going. In some mobile units a doctor and two nurse combination is considered adequate but to my mind this reacts detrimentally as regards the actual number of children who can be immunised per session. The doctor and two nurse system was tried out originally in our pilot scheme but half-way through the first session it was found to be absolutely impracticable and, to avoid a complete collapse of the scheme, additional nurses had to be rushed along to give assistance. It was discovered at subsequent sessions that a doctor assisted by two nurses in the van and three acting as auxiliaries, so ensuring a steady flow to the van, gave the maximum co-ordination possible. Whilst this unit can be put to the best economic advantage in a populous urban area, there is no reason whatsoever why it should not be used to carry immunisation to outlying areas, and here the doctor and two nurse combination would probably be used to better advantage. Before the unit can be expected to function successfully, a vast amount of preparatory work must be carried out by the Health Visitors and the office staff, the latter selecting those children whose parents cannot or will not bring their children to the static clinics. The Health Visitors have to personally contact each parent beforehand notifying them that the van will be round on a certain day later in the week. A few days before the unit is sent out, a loud-speaker van touring the selected districts further notifies all the residents that the unit will visit that district on a selected day. Later, when the unit makes its tour, the loud-speaker can with equal advantage be mounted on the vehicle and operated by the driver who should be accustomed to this type of broadcasting. The use made of this mobile unit immunisation van will probably vary from Division to Division, but it should undoubtedly fulfil a definite need in all of them. Indeed, it is felt when once the vast potentialities of this set-up are appreciated and full use is made of it, the services of more than one unit will probably be required to satisfy all the demands put upon it. It may be that experience will dictate that a smaller type of vehicle can appropriately be used in serving the needs of scattered rural areas, though it must be emphasised again that a commodious type of vehicle should definitely be employed where congested urban populations are to be catered for. It must not be forgotten that this type of set-up is restricted to functioning during the summer and autumn months and any attempt to extend it for a longer period than that will inevitably be doomed to failure. Indeed, even so, I feel that September is late enough. The question of securing efficient sterilisation of needles, swabs, etc., will also have to be given consideration, because it will be found practically impossible to carry this out when the unit is in operation and the provision of a small but efficient portable autoclave should be given serious consideration.

The future progress of immunisation will almost certainly depend on consolidating and effecting improvements on existing methods. The main brunt of the attack must still and always will be borne by the static immunisation clinic, which attack it can sustain by reason of the fact that it can function independently of the weather be it summer or winter, and the mobile unit can be called into use as an auxiliary method to deal with what may be called the problem type of immunisation."

As a result of the intensive effort at Castleford, the records at the end of the year showed that 84% of the total child population in the Castleford Division between the ages of 0 and 15, had completed a full course of primary immunisation.

The immunisation state of children in the whole of the Administrative County as at 31st December, 1949, was as follows:—

Age at 31.12.49. i.e. born in year :—	Under 1 1949	1 1948	2 1947	3 1946	4 1945	5—9 1940-44	10—14 1935-39	Total under 15
Number Immunised	1,868	13,541	17,905	16,485	15,012	75,847	68,119	208,777
Estimated Mid-year Population 1949	Children under 5					Children 5—14		
Percentage of population immunised	138,680					218,900		357,580
	46.7					65.8		58.4

During the year there were 4 deaths from diphtheria in children under 15 years of age, one of the deaths occurring in a child aged 2 years 8 months who had completed a course of primary immunisation in 1947 at the age of 17 months. This was a case of laryngeal diphtheria, the doctor not being called in until 3 days after the onset of the disease. Anti-toxin was administered and the child was admitted to isolation hospital but died the following day.

Poliomyelitis

There was a recrudescence in the prevalence of acute poliomyelitis and acute poliomyelitis (infantile paralysis) after the decrease in 1948. The epidemic proportions of the 1947 outbreak were not reached, despite the fear of this, to which the number of cases arising in the beginning gave rise. The increase in incidence began to show itself in July—a month later than was the case in 1947—and reached its highest point during the week ended Saturday, the 3rd September, when 23 cases were notified. It decreased in the following weeks but the prevalence did not commence definitely to die down until the third week in November. The number of confirmed cases was 250 (400 in 1947) and there were 28 deaths, the case mortality rate being 112 per 1,000 (87.5 in 1947).

The age distribution of the cases was as shown below:—

Age Group. Years.	Number of cases.	Percentage to total cases.	
		1949	1947
Under 1.	16	6.4	4.0
1 and under 3	43	17.2	16.7
3 „ „ 5	33	13.2	16.8
5 „ „ 10	68	27.2	13.0
10 „ „ 15	31	12.4	11.3
15 „ „ 25	33	13.2	20.2
25 and over.	26	10.4	18.0

It will be observed that as compared with the 1947 outbreak, the percentage of cases in 1949 was double in the 5 to 10 age group, but considerably lower in the age groups 15 and under 25 and 25 and over. We do not know the reason for this.

The cases in 1949 were scattered fairly evenly throughout the Administrative County, only 12 of the 68 Boroughs and Urban Districts and 8 of the 21 Rural Districts being without a case.

Smallpox

There was no case of smallpox in 1949. No change in procedure to that described in my last Annual Report has taken place in connection with vaccination against smallpox. The following table sets out the figures relating to vaccinations performed during 1949:—

Number of persons Vaccinated and Revaccinated.

				Under 1	1 to 4	5 to 14	15 or over	Total
Vaccinated	...	...	...	2,208	1,609	263	381	4,461
Revaccinated	...	...	...	7	12	46	576	641
Total				2,215	1,621	309	957	5,102

In certain parts of the County, special vaccination clinics are held periodically, e.g., weekly clinics are held at Harrogate and Shipley, fortnightly clinics at Guiseley, and monthly clinics at Skipton. Generally speaking, vaccinations are carried out at Infant Welfare clinics in all cases where parents wish the vaccinations to be performed by the Local Health Authority, but reports have been submitted by Divisional Medical Officers to the effect that “mothers are just not interested in the offer of vaccination in the Infant Welfare Clinics” or “efforts are made to encourage vaccination at Infant Welfare Clinics but they have met with little success.” A criticism which has been met with is that “some Medical Officers are not very enthusiastic regarding vaccinations and prefer not to carry out vaccinations at Infant Welfare Clinics” whilst from another area came the comment “only about 60% of the parents consenting brought their infants to be vaccinated at the clinics arranged, although the clinics were carefully placed and timed for their convenience.”

Propaganda is effected by various means in different parts of the County, e.g. by the distribution of cards to the parents of all young children during their first month of life, by leaflets distributed by Health Visitors, and by personal approach by Health Visitors. One of the Divisional Medical Officers (Dr. Ward) reports “some Health Visitors feel that the lack of success is due to the fact that there is no national propaganda in favour of vaccination as there is regarding diphtheria immunisation, and from this fact argue that it cannot be as important,” whilst Dr. Eustace reports “valiant attempts have been made to disseminate propaganda through the Health Visiting Staff, but the deep rooted inertia which is so obvious will take much time to remove. In Swinton and Rawmarsh Urban Districts there were no infants under one year of age vaccinated at all and here again it is felt that the value of a suitable instructional film would do much to encourage vaccination in the Division.” Health Visitors discuss the question of vaccination on the occasion of first visits to new babies and parents are advised as to when and where vaccinations can be obtained.

Venereal Diseases

During 1949 a revised form of the Annual Return made by Medical Officers of Treatment Centres to Medical Officers of Health was introduced by the Ministry of Health. The latest form does not give the total attendances of County patients, and the new cases of Chancroid attending Special Clinics from the Administrative County area have been grouped together with Other Conditions. The reasons for altering the lay-out of the Annual Return appear to be (a) simplification and (b) the fact that the Counties and County Boroughs are no longer responsible for the financial upkeep of the Treatment Centres. The loss of the information in the Annual Return has been more than compensated for by obtaining details of numbers of cases of early, late and congenital syphilis. This information has never been available previously and has been obtained by close co-operation between members of the Public Health V.D. Staff and the Medical Officers of the Treatment Centres.

The total number of new cases from the Administrative County attending Special Treatment Centres during 1949 was 2,178. This figure is 1,544 fewer than the peak year of 1946 but 883 more than in 1940. New cases of gonorrhoea have fallen to the record low level of 383. In the vast majority of cases of gonorrhoea the infection can be rapidly brought under control by modern methods of treatment and there is some reason to believe that the peace time incidence of this disease is falling and may continue to fall provided a penicillin resistant strain of gonococcus does not develop. Twenty-eight fewer new cases of syphilis from the West Riding Administrative County area attended the Special Treatment Centres. The apparent incidence of this disease fell steadily in the years between the wars and since 1946 the new cases have dropped in number from 723 to 435. This downward trend is also revealed in the returns from the General Practitioner V.D. Service, the 1946 and 1949 figures being 64 and 22 respectively.

The following table gives the number of new patients who attended Treatment Centres during 1938 to 1949. In this and all other tables the figures given relate only to persons residing in the Administrative County:—

Year	Syphilis	Soft Chancre	Gonorrhoea	Total new V.D. cases	Other conditions	Total new patients
1938	346	2	650	998	501	1,499
1939	403	4	678	1,085	589	1,674
1940	299	2	499	800	495	1,295
1941	331	2	552	885	585	1,440
1942	423	1	479	903	734	1,637
1943	487	2	654	1,143	1,342	2,485
1944	413	1	560	974	1,382	2,356
1945	473	2	767	1,242	1,417	2,659
1946	723	2	1,140	1,865	1,857	3,722
1947	573	1	729	1,303	1,510	2,813
1948	463	—	550	1,013	1,403	2,416
1949	435	* —	383	818	1,360	2,178

* Included in "Other conditions."

The table below is compiled from the new registrations at Special Treatment Centres:—

Quarter ended.	Acquired Syphilis		Congenital Syphilis		Gonorrhoea	Other Conditions
	Early	Late	Under 1 yr.	Over 1 yr.		
31st March	46	46	4	17	106	364
30th June	43	54	3	18	89	366
30th September	39	48	—	17	101	322
31st December	30	54	—	16	87	308
Total	158	202	7	68	383	1,360

This information is of considerable importance in that it gives a better epidemiological picture of syphilis. For the purposes of this return early syphilis includes the primary, secondary and latent stages of less than 1 year's duration and late syphilis all the other stages of the acquired form of disease. It is interesting to note that of the 75 cases of congenital disease 7 were in infants. With modern methods of treatment congenital syphilis is a preventable disease. By adequately treating all expectant syphilitic mothers the incidence of this form of disease could be brought to nought. Careful ante-natal examinations and routine blood testing will bring to light the majority of cases and the occurrence of 7 cases of congenital syphilis might at first sight appear to be a reflection on the thoroughness of the ante-natal work. Investigation has shown, however, that in each of the 7 cases the expectant mother was either un-co-operative or had not attended an ante-natal clinic. It may be that the solution will be in further education of the public and in particular of prospective mothers.

The following table shows the distribution at the various Treatment Centres of the 2,178 new cases:—

	Syphilis	Gonorrhoea	Non-Venereal
Barnsley Clinic, Queen's Road ...	14	28	90
Bradford, St. Luke's Hospital ...	36	26	91
Burnley Victoria Hospital ...	2	2	4
Dewsbury General Infirmary ...	49	26	81
Doncaster M. & C.W. Centre ...	—	9	—
Doncaster Royal Infirmary ...	40	67	47
Goole Bartholomew Hospital ...	3	3	38
Halifax Royal Infirmary ...	31	20	55
Harrogate General Hospital ...	22	16	85
Huddersfield V.D. Centre ...	13	16	52
Keighley Victoria Hospital ...	21	24	132
Leeds General Infirmary ...	60	41	252
Oldham Royal Infirmary ...	2	6	11
Rotherham W.R. Medical Centre ...	31	22	67
Sheffield Jessop Hospital ...	—	3	7
Sheffield Royal Hospital ...	3	8	14
Sheffield Royal Infirmary ...	8	8	22
Sheffield City General Hospital ...	2	—	1
Wakefield Clayton Hospital ...	97	58	279
York County Hospital ...	1	—	32
	435	383	1,360

General Practitioner V.D. Service—Since the inception of this service there has been one General Praetitioner in the area which now comes within the limits of the Sheffield Regional Hospital Board. During 1949 the supervision of the V.D. work of this practitioner was transferred to Dr. D. Campbell, Consultant Venereologist, Sheffield. The remaining 14 General Praetitioners in the service have worked under the direction of the County Venereologist who acts as Consultant and advises on difficulties of diagnosis and treatment. The following table shows the work performed by General Praetitioners:—

	1948				1949			
	Cases under treatment at 1st Jan. 1948	New Cases	Cases transferred to the General Practitioner	Total Attendances	Cases under treatment at 1st Jan. 1949	New Cases	Cases transferred to the General Practitioner	Total Attendances
Syphilis ...	86	42	17	1,773	88	37	15	1,494
Gonorrhoea ...	34	34	5	331	16	12	2	138
Non-venereal and other undiagnosed conditions ...	11	123	—	498	9	88	5	296

V.D. Social Work and Contact Tracing—The staff consists of 4 whole-time Health Visitors, who are trained nurses with Health Visitor's qualifications and special experience in venereal diseases work. There is 1 confidential clerk-typist. The County has been divided into 4 areas and each V.D. Health Visitor is responsible for the tracing of contacts, follow-up of defaulters and venereal diseases social work at one or more of the elinies in her own area. The County Boroughs of Doneaster, Dewsbury and Wakefield share in this service. When working at elinies within her area the Health Visitor comes under the immediate direction of the Venereal Diseases Specialist in charge of the elinie:—

The tables below give statistics as to the investigation of contaacts by the Venereal Diseases Health Visitors:—

Total number of contacts reported ...						206
Located and examined ...						
Not infected ...					106	164
Infected ...					58	
Already under treatment ...				12		
Brought under treatment ...				46		
Syphilis ...	31					
Gonorrhoea ...	15					
Located and not examined ...						15
Not located ...						27
Insufficient information ...					11	
Unable to locate ...					6	
Transferred to other authority ...					10	

The total number of re-visits made to contacts was 118. and the total number of ineffective visits 180.

Contact investigation includes not only the bringing under treatment of contagious cases of early venereal disease but also arranging for the examination of any person who may have untreated venereal infection at any stage of the disease. For example, if a child is found to have congenital syphilis the parents and other children in the family are examined. In this way new cases may be found and treatment commenced before the development of gross and crippling physical signs. It will be noted that excluding 10 persons who had removed from the Administrative County only 17 cases out of the 206 reported were not located. The ineffective visits were those in which the Venereal Diseases Health Visitor was unable to speak to the contact privately or the contact was away from home. Re-visits refer to those in which a second or third visit was necessary before the contact attended for examination.

DEFAULTERS:—

Total No. of defaulters	Returned to Clinic after visiting	Failed to return	Removed unable to locate	Transferred	No. of ineffective visits	No. of re-visits
471	253	150	31	37	682	497

The word “defaulter” refers to known cases of venereal disease who cease to attend for treatment before they are cured. They fall into two main groups (1) those who have been partially treated and (2) those who have finished treatment but cease to attend before the necessary periods of observation and tests of cure have been completed. It is the Social Worker’s duty in her work at the Clinic to find out patients’ home difficulties and by solving these problems remove conditions which might otherwise lead to patients defaulting. From the point of view of both public health and that of the individual group (1) is by far the most important and every possible step is taken to ensure that patients attend until they are rendered non-contagious.

Reasons for defaulting are legion and include domestic troubles, illness of the patient, awkward hours of work, fear of being seen attending the clinic, absence of symptoms and many others. The principle methods of getting in touch with the defaulting patient are by letters or by visits by Social Workers. In suitable cases other means are adopted but whatever method is used the greatest care and tact are necessary at all times.

The work of Prevention in relation to Positive Blood Tests for Syphilis—Following a meeting of Pathologists, Venereologists and representative Medical Officers of Health at Wakefield during 1949, it was agreed with laboratories undertaking serological tests that they would submit to the County Venereologist the name of the doctor, hospital or clinic sending in a specimen which proved to be positive for syphilis. In addition a letter approved by a Sub-Committee of the meeting and the West Riding Local Medical Committee was sent to all General Practitioners in the Administrative County explaining the action we proposed to take on receiving information from a laboratory. Briefly this consists of a letter to the doctor concerned offering him the services of one of our V.D. Social Workers in dealing with the case and in arranging for the examination of contacts. This work has not been in operation for a long enough time to assess the results, but it is clear that important results will accrue from this scheme, and already several unsuspected cases of V.D. have been brought under examination and treatment. It is hoped to give full statistical details in next year’s report.

Ophthalmia Neonatorum

Fifty years ago it was found in some areas that more than a quarter of the blind, or partially blind, children were attributable to ophthalmia neonatorum which is defined in the Regulations making it notifiable as “a purulent discharge from the eyes of an infant commencing within 21 days from the date of its birth.” Precautions for its prevention can be taken at birth. The Rules of the Central Midwives Board require midwives to take precautions and there is no doubt that this is responsible for the reduction in the number of cases from the annual average of 230 thirty years ago.

If the condition is left untreated, or treatment is not applied soon enough, blindness, total or partial, might ensue. The Regulations require early notification. In 1949, there were 37 confirmed cases of ophthalmia neonatorum, 28 of which were treated at home and 9 in hospital. Of these, the vision was unimpaired in 35 and impaired in 1; one case was still under treatment at the end of the year.

Tuberculosis

1,982 new cases of tuberculosis were notified during the year compared with 1,796 last year and an average of 1,684 in the five years 1944-48. There were 1,526 respiratory and 456 non-respiratory cases; details are summarised in the following table:—

	AGE PERIODS													Total (all ages)
	0—	1—	2—	5—	10—	15—	20—	25—	35—	45—	55—	65—	75—	
FORMAL NOTIFICATIONS:—														
Respiratory, Males	2	3	11	21	22	50	96	169	133	136	105	39	9	796
Respiratory, Females		5	17	29	36	91	112	176	71	41	19	9	4	610
Non-Respiratory, Males	4	13	33	61	33	13	9	15	7	8	3	5		204
Non-Respiratory, Females	3	8	40	38	35	16	11	21	14	9	9			204
SUPPLEMENTAL NOTIFICATIONS:—														1,814
Respiratory, Males	2		1	1	3	2	4	11	6	13	15	14	6	78
Respiratory, Females			1		1	1	9	10	4	4	7	5	1	42
Non-Respiratory, Males	3	1	2	4	2	2	1	3	3	3	1	1	1	23
Non-Respiratory, Females	3		3	3	2	2		5	3	2	1	1		25
														168

The sources of information of the supplemental notifications were:—

Local Registrars (40 respiratory, 9 non-respiratory); transferable deaths from the Registrar General (21 respiratory, 11 non-respiratory); posthumous notifications (11 respiratory, 3 non-respiratory); transfers from other areas (35 respiratory, 15 non-respiratory); other sources (13 respiratory, 10 non-respiratory).

After adjustments for removals, recoveries and deaths, the total number of cases remaining on our registers at the end of the year was 9,324, an increase of 321. 6 per thousand of the County population are known to be suffering from the disease. (The rate varies from 2 to 17 per thousand).

PUBLIC HEALTH (TUBERCULOSIS) REGULATIONS, 1930

Table shewing Revision of Notification Registers by Medical Officers of Health

Division No.	Number of cases on register 1/1/49.				Number of cases added to register.				Number of cases removed from register.				Number of cases remaining on register 31/12/49			
	Respiratory M	Non-Resp. F	Respiratory M	Non-Resp. F	Respiratory M	Non-Resp. F	Respiratory M	Non-Resp. F	Respiratory M	Non-Resp. F	Respiratory M	Non-Resp. F	Respiratory M	Non-Resp. F	Respiratory M	Non-Resp. F
1	175	111	48	64	21	14	11	11	17	4	6	6	179	121	53	69
2	45	18	15	10	9	10	4	6	6	5	1	—	48	23	18	16
3	93	65	31	20	30	29	13	8	20	12	3	3	103	82	41	25
4	212	207	64	75	60	43	21	20	96	103	13	24	176	147	72	71
5	171	134	53	58	54	26	13	9	35	26	8	8	190	134	58	59
6	201	130	75	69	22	9	5	7	14	12	2	6	209	127	78	70
7	32	29	17	17	16	8	5	6	12	17	5	7	36	20	17	16
8	175	131	71	92	56	60	7	13	33	30	7	9	198	161	71	96
9	69	68	40	39	12	15	12	7	17	9	7	8	64	74	45	38
10	98	70	35	36	21	16	12	7	13	11	4	3	106	75	43	40
11	157	143	43	43	47	25	7	3	26	23	4	1	178	145	46	45
12	169	106	53	61	27	20	5	9	34	14	5	7	162	112	53	63
13	72	50	32	34	20	16	6	3	30	24	17	21	62	42	21	16
14	52	42	11	35	16	10	4	6	7	10	1	6	61	42	14	35
15	52	47	33	26	15	12	4	9	11	7	1	2	56	52	36	33
16	94	97	43	33	32	29	6	2	9	25	11	3	117	101	38	32
17	143	86	67	65	23	16	6	7	17	9	8	3	149	93	65	69
18	124	69	59	39	32	25	6	4	29	21	10	17	127	73	55	26
19	126	79	100	109	31	18	7	2	21	15	14	28	136	82	93	83
20	77	58	38	40	31	30	13	24	19	13	7	13	89	75	44	51
21	19	10	9	9	3	5	1	4	4	5	2	1	18	10	8	12
22	184	129	82	55	47	33	21	19	40	16	13	20	191	146	90	54
23	166	113	42	52	50	39	9	10	26	18	5	9	190	134	46	53
24	50	35	20	15	24	18	4	5	13	8	4	9	61	45	20	11
25	95	68	16	30	36	33	6	4	14	14	4	5	117	87	18	29
26	81	48	27	23	14	13	5	10	13	14	5	4	82	47	27	29
27	106	70	57	44	30	20	4	3	23	3	4	1	113	87	57	46
28	115	85	68	63	22	28	10	8	20	17	5	4	117	96	73	67
29	96	66	41	29	18	21	5	7	20	9	10	7	94	78	36	29
30	182	144	39	36	84	53	13	12	70	42	10	18	196	155	42	30
31	196	131	44	43	28	24	12	5	66	48	13	14	158	107	43	34
Total	3627	2639	1373	1364	931	718	257	250	775	584	209	267	3783	2773	1421	1347

Thus, tuberculosis continues to be a great evil, costly in suffering, in the harm it does to industry, and in the use of skilled services and hospital beds. In a picture which is almost wholly encouraging, tuberculosis stands out as a gloomy and sombre prospect. It was among the first of the great community health mysteries to be unravelled and a service for its eradication was created over 30 years ago when personal preventive medicine was in its infancy. Other great scourges are disappearing; why does this one linger and why, after so much money and effort has been spent on it, should it now again increase? We know all the essential facts for its eradication. Is the answer then that we do not apply this knowledge and, if so, why not?

Whatever may have been good or bad about the tuberculosis service, it has now gone. In its place we have two separate responsibilities, one for cure and one for prevention. Separation of responsibility in itself does no grave harm, for two parts can work together as one whole, given the will. The disadvantage and the danger come from the shift of emphasis from prevention to cure. Is it not significant that the "tuberculosis officer" is now a "chest physician"? That is the epitome of what has happened; a disease which embraces the whole life of the community, its housing, its town planning, its cattle and milk supplies, its schools and its nurseries, its workplaces and factories, its mines and mills, is now a matter of the chest. This particular problem of community health needs the widest possible approach. It is this approach which now is lacking, we shall not move forward without it, whether the service remains divided or is again united.

Much good would have come from the use of the chest physician as a bridge between the two complementary services (Circular 118/47 emphasised the importance of joint appointments between the Regional Boards and the Local Health Authorities). Unfortunately, this intention has not materialised (now two years after the appointed day). I am indebted to all our former tuberculosis officers for their collaboration.

B.C.G. Vaccination—Infection by the tuberculosis bacillus may, instead of causing the disease, develop in the infected person an immunity against further attacks. For this purpose it is essential that the degree of infection should be controlled and on the basis of this information scientists have sought to control primary infection by immunisation in a manner similar to that of vaccination against smallpox and immunisation against diphtheria. By a process of sub-culture of a bovine type of the tuberculosis bacillus, the French scientists Calmette and Guérin produced a strain of low virulence, subsequently named after them, which has maintained uniformity in virulence and character over a number of years. B.C.G. (Bacillus Calmette-Guérin) has been extensively used in Europe, and particularly in the Scandinavian countries, over a number of years. It is not yet certain that B.C.G. gives complete immunity against the disease and only experience will shew how far its use will be effective in this country. Its use at least reduces the risk of contracting tuberculosis, and where a vaccinated person later contracts the disease its effects are less severe. After a careful study of the evidence in its favour the Ministry of Health has made arrangements for the use of B.C.G. in this country within certain limitations and under controlled conditions.

Insofar as its use outside hospitals is concerned the Ministry has indicated (Circular 72/49) that while the vaccination must be undertaken by chest physicians, it will be in the capacity of their service to the Local Health Authority, and the arrangements must be within the scope of the Local Health Authorities arrangements for the prevention of tuberculosis under Section 28 of the National Health Service Act. In the light of these considerations the County Council obtained the Minister's approval to the inclusion of the following supplemental proposal in the approved scheme:—

"The Local Health Authority intends to provide for B.C.G. vaccination, by and at the instance of a physician with specialist knowledge and experience of tuberculosis, as regards persons to whom it is judged medically expedient, subject to the necessary preliminary tests, to offer such vaccination in view of their known contact with tuberculosis infection. Records of B.C.G. vaccinations will be kept in such standard form as may be recommended by the Ministry, and information concerning these records will be supplied to the Ministry on request."

The Minister further asked for the names of the individual chest physicians by whom it was intended that the vaccination would be carried out. This request was the cause of some embarrassment in that there are no chest physicians in the joint service of the Regional Hospital Board and the County Council. A compromise solution, agreed by the interested parties, was the submission of the names of the senior chest physicians formerly employed by the County Council. It will be realised, however, that this arrangement leaves appreciable parts of the County area without such facilities. The procedure for vaccination requires an initial test to ensure that the subject has not already been infected and then, except in the case of new born babies, the subject must be isolated from all known sources of infection, if necessary by segregation, for a period of six weeks by which time any acquired infection can be demonstrated and a second test is made for that purpose. If the second test is negative, vaccination is done after which it is again necessary to protect the subject from known sources of infection for periods of from 6 to 12 weeks, when a final test is made which, if the vaccination has been successful, will then give a positive result. There are provisions for subsequent X-ray examinations and follow-up of the vaccinated cases.

The limitations imposed by the Minister preclude the vaccination of any cases other than those known to be contacts of persons suffering from tuberculosis. Within this limited field there remain problems requiring an early solution. Since vaccination may only be undertaken by Chest Physicians we must have access to, and co-operation with, Chest Physicians for the whole of the County area. There is considerable emphasis on the need for segregation, designed to preserve the reputation of B.C.G. and, where this cannot be arranged either by the temporary removal of the source of infection or by the transfer of the subject to the temporary care of relatives or friends, it will be necessary for the County Council to provide special hostel accommodation for that purpose. The problems which are presented are being considered in detail with a view to our taking a full part in this new venture.

Mass Radiography—The removal of mass radiography from the health department was a mistake. We are seeking agreement with the Medical Directors and Chest Physicians to secure that mass radiography is directed against the most susceptible part of our population.

A brief summary of the Surveys undertaken by the Sheffield and Leeds (West Riding) Units is given below. The findings of the Sheffield Unit are not completed but those of the Leeds Unit serve to confirm the previously expressed view that active and unknown cases of tuberculosis are present in the community at the rate of 5 per 1,000 of the population, i.e., that in the County area there are approximately 7 to 8,000 unnotified cases of tuberculosis liable to be spreading infection. Add to that the known sources of risk and one in every hundred persons is afflicted by the malady. The loss of human happiness, of economic productivity, and the enormous cost of treatment suggested by these figures alone is sufficient to demand that any measures designed for prevention should be used to the best advantage.

MASS RADIOGRAPHY SURVEYS - 1949

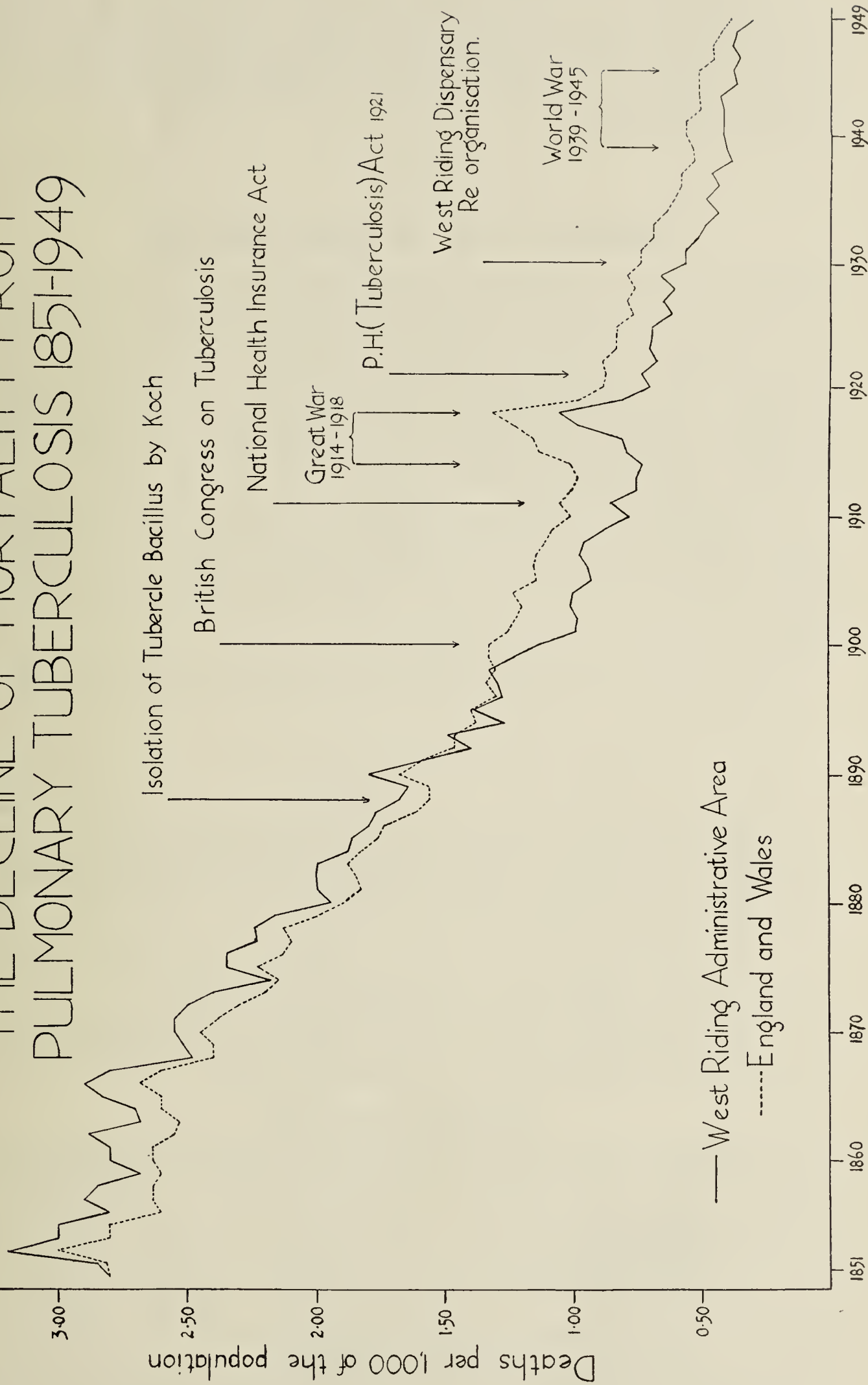
Survey undertaken at	No. Examined.	Abnormalities Discovered.		Total.
		Tuberculosis.	Others.	
	A. SHEFFIELD UNIT.	Suspected†		
British Railways, Doncaster. ...	3,780	32	35	67
Crompton Parkinson, Doncaster ...	1,207	20	6	26
Peglers Ltd., Doncaster. ...	1,202	7	14	21
British Ropes, Doncaster. ...	1,142	6	27	33
Divisional Health Office, Mexborough	5,447	54	97	151
National Coal Board:—				
Hickleton Main ...	1,467	21	57	78
Rossington Main* ...	2,142	31	66	97
Yorkshire Main ...	1,477	27	75	102
Pilkington Bros., Kirk Sandall ...	1,114	9	24	33
Rockware Glass Syndicate ...	689	9	14	23
.	19,667	216	415	631
	B. LEEDS UNIT.			
		Active.	Inactive	
Ripon ...				
Uppermill ...				
Greenfield ...				
Springhead ...				
Cleckheaton ...				
Pontefract ...	22,840	118	172	255
Glasshoughton ...				
Saltaire ...				
Keighley ...				
Otley ...				
Ryhill ...				
Criggleshole ...				
Brighouse ...				
Elland ...				
Harrogate ...				
	42,507	206	300	670
				1,176

*The examined include 254 from the Rossington Modern School and 65 miscellaneous personnel.

†The suspected cases of tuberculosis include "known" cases, 1 each from Crompton Parkinson, Rossington Main, Rockware Glass Syndicate, 2 from Yorkshire Main and 3 from Hickleton Main.

- NOTES: 1. The grand totals of active and inactive tuberculosis discovered are hypothetical, based on the assumption that the final diagnosis of the 216 suspected cases, referred by the Sheffield Unit, will be a confirmation with a ratio of active-inactive equal to that revealed by the Leeds Surveys.
2. The 255 non-tuberculosis abnormalities revealed by the Leeds Surveys are classified as follows:—
- | | | | |
|--|-----|-----|----|
| Abnormalities of bony thorax and lungs | ... | ... | 8 |
| Chronic bronchitis and emphysema | ... | ... | 20 |
| Consolidation of unknown cause | ... | ... | 1 |
| Bronchiectasis | ... | ... | 41 |
| Pulmonary fibrosis; post-pneumonic | ... | ... | 10 |
| Pneumoconiosis | ... | ... | 55 |
| Basal fibrosis | ... | ... | 9 |
| Pleural thickening | ... | ... | 34 |
| Intrathoracic tumours | ... | ... | 2 |
| Cardio vascular lesions—congenital | ... | ... | 1 |
| „ „ „ „ acquired | ... | ... | 60 |
| Miscellaneous | ... | ... | 14 |

THE DECLINE OF MORTALITY FROM PULMONARY TUBERCULOSIS 1851-1949



MATERNITY AND CHILD WELFARE

The preventive care of the mother and her young child, which has been one of the most successful developments of social medicine, has lost none of its importance to present day society. The truth of this is recognised in the National Health Service Act, which makes little, if any, alteration in the responsibility of the Medical Officer of Health for this work. The service entails provision for ante-natal care, post-natal care, domiciliary midwifery, infant welfare, the care of the unmarried mother and her child, and the day-time care of the child whose mother is at work (in nurseries or by minding).

PART III

MIDWIFERY AND MATERNITY SERVICES

Introduction—The birth of a baby, as a physiological process, should take place in the family home, and it should be one of the objects of the community health service to make this possible. The proposals of the Royal College of Obstetricians and Gynaecologists (for a 75% delivery of babies in institutions) are neither desirable nor wholly practicable. There is a danger that the public may be brought to believe that hospitals are the best places in which to have babies. For many years an unsatisfactory environment will force mothers to have their babies away from home but we should now be striving not to multiply institutional beds but to make homes fit for babies to be born in. A figure of 50% institutional delivery is a reasonable upper limit to meet present day contingencies (compare 52% last year in the West Riding, representing an increase of 6% over 1948) providing the beds are used to the best advantage. Admission to a maternity home or hospital for normal midwifery should only be arranged where the need is certain.

The whole midwifery service should be centred upon the home and not upon the hospital. A well organised service for ante-natal care will reduce to a minimum the occurrence of untoward events at home and secure that all or most women in need of special care will have been removed to hospital. The fact that such complications do occasionally arise at home does not justify the centring of the whole midwifery service upon the hospital. Full support must be given to the training and practice of domiciliary midwives. A domiciliary midwifery service should make provision to meet all contingencies and should include:—

(i) The provision of special clinics staffed by an obstetric consultant (in addition to ante-natal clinics for routine supervision and teaching) to which special cases of difficulty can be referred. These centres should be in centres of population, in general away from out-patient departments.

(ii) The provision of hostels in the form of rest homes for mothers not in need of hospital care, and special provision for the unmarried.

(iii) Arrangements for care by a general practitioner. Every mother should (as now) be able to book a general practitioner to be responsible for her pregnancy, labour and lying-in at home. The general practitioner should undertake full responsibility (assisted by routine supervision and teaching at a clinic); he should (in collaboration with the Medical Officer of Health) arrange for cases of difficulty to be booked for institutional delivery; he should be enabled to call in an obstetric specialist (or the "flying squad" mentioned below) in case of sudden unforeseen emergency.

(iv) Arrangements whereby a midwife can obtain assistance from a doctor; if no doctor has been booked she should be able to call in any general practitioner obstetrician. (In such cases the fee can properly be borne by the community health authority).

(v) Arrangements for a flying squad to be available to deal with emergencies arising during pregnancy, which have to be dealt with in the patient's own home; the midwife must be in a position to call upon such help as a life-saving measure.

Institutional Midwifery

As indicated in my report last year, we have had difficulty in getting full information about institutional deliveries. The following information has been compiled from the birth notifications.

Number of patients confined in:—						Percentage to total births	
Maternity Homes	...	...	...	...	...	5,199	18.7
Hospitals and Institutions	...	...	...	...	...	7,724	27.7
Private Nursing Homes	...	...	...	...	...	1,275	4.6
				...	...	<u>14,198</u>	<u>51.0</u>

Domiciliary Midwifery

The County Council remains the local supervising authority. 527 midwives gave notice to practise in 1949; of these 350 were whole-time County Council midwives (104 of these undertook combined duties of midwifery and home nursing); 50 were engaged in private practice and 127

in institutions. As indicated in my report of 1947, the separation of midwifery from general nursing progresses slowly; there are 104 nurses undertaking combined midwifery duties as compared with 156 when the nursing service was taken over.

The non-medical Supervisors of Midwives made visits as follows:—

To midwives; supervision of practical work	304
To patients in labour	25
To ante-natal and lying-in patients	788
Routine visits to midwives	568

Special enquiries, etc., were made as follows:—

Puerperal pyrexia and pemphigus neonatorum	61
Deaths of mothers	11
Ophthalmia Neonatorum	8
Visits with, and tutorial classes for, pupil midwives ...	30
New midwives equipped and instructed	29
Inspection of registered nursing homes	11
Visits to Divisional Medical Officers	176

Under the National Health Service Act the general practitioner must examine the patient when she books, at the 36th week, and six weeks after confinement; he must attend her, if necessary, at any time. He need not give regular ante-natal supervision, nor need he attend during labour (unless he himself or the midwife thinks this to be necessary). The relative responsibilities of general practitioners and midwives have been the subject of a statement issued to general practitioners by the Standing Maternity and Midwifery Advisory Committee of the Central Health Services Council. This mentioned the widespread erroneous belief that when a doctor was booked the case became a "doctor's case." The statement emphasised that the scheme did not diminish the importance of the midwife, or the local authority clinic; the maternity medical service was, in fact, meant to supplement what already existed. The difficulties have not yet been wholly overcome.

Domiciliary midwives attended 13,348 deliveries (11,313 solely as midwives and 2,035 as maternity nurses). Midwives called for "medical aid", as they must, in the following instances:—

Summary of conditions for which medical aid was summoned.

PREGNANCY (966)

Abdominal Pains	29	High blood pressure	33	Pyelitis	3
Abortion	217	Hydramnios	4	Pyrexia	1
Abscess of Vulva	1	Hyperemesis	5	Rash	2
Absence of Foetal movement	2	Hypertension	3	Renal condition	1
Albuminuria	62	Influenza	4	Retention of Urine	2
Anaemia and Debility	20	Jaundice	1	Rhesus Negative	4
Ante-natal exam	6	Large right Ovarian Cyst	1	Rheumatism	1
Ante-partum Haemorrhage	186	Malpresentation	21	Ruptured Membrane	24
Blood Test	1	Mental condition	1	Slow Dilatation	3
Cardiac condition	6	Miscarriage	56	Threatened abortion	120
Chest conditions	4	Mitral Stenosis	2	Threatened Miscarriage	15
Contracted Pelvis	1	Neurotic	1	Thrombosis	1
Cystitis	3	Oedema	24	To give a sedative	6
Discharge	2	Pain in back	1	Toxaemia	39
Disproportion	7	Pain in side	2	Transverse Presentation	2
Dyspnoea	1	Persistent Headache	1	Twin Presentation	2
Early Bleeding	2	Persistent Vomiting	1	Uterine haemorrhage	1
Eclampsia	3	Position	2	Uterine Pain	1
Gas and Air exam	1	Post Maturity	3	Varicose Vein	4
General Condition	10	Pre-Eclamptic	1	Vertex not entering brim	1
Head above brim	1	Prolapsed Uterus	1		

LABOUR (3177)

Abscess of Labia	1	Face presentation	3	Obstructed labour	37
Abdominal pains	6	Foetal distress	34	Persistent posterior	3
Abnormal Presentation	6	Foot presentation	12	Placenta Praevia	11
Abrasion	2	Forceps delivery	1	P.O.P.	1
Acute pain	5	Gas and Air exam	3	Post Partum haemorrhage	126
Breech presentation	64	General condition	17	Precipitate labour	16
Cardiac condition	1	Haematoma	1	Premature labour	83
Chest conditions	2	Haemolytic Strep. infection	1	Prolapse of cord	4
Collapse of patient	4	Hydramnios	1	Prolonged labour	442
Contracted pelvis	2	Hysteria	7	Prolonged 2nd stage	7
Cord presentation	1	Inflammation of eyes	1	P.V.	1
Delayed labour	48	Intro-Cordia Haemorrhage	1	Retained Placenta	141
Difficult labour	2	Kidney condition	1	Rigidity of cervix	31
Disproportion	3	Loss of blood	41	Ruptured perineum	1782
Early rupture of membranes	6	Malpresentation	62	Sedative 1st stage	6
Eclampsia	8	Maternal distress	9	Stillbirth	1
Emergency delivery	16	Multiple pregnancy	5	Transverse Presentation	4
Epilepsy	1	No cause given	8	Uterine inertia	98
Episiotomy	6	Obstetric shock	6	Vaginal lacerations	22

LYING-IN (477)

Abdominal pains	19	Influenza	5	Rheumatism	1
Anaemia and Debility	28	Mastitis	48	Right eye swollen	1
Blood test	12	Nasal haemorrhage	1	Rigors	1
Bronchitis	2	Oedema	4	Rise of temperature	37
Cardiac conditions	4	Offensive Lochia	10	Rupture of Membranes	2
Chest conditions	6	Pain in head and face	1	Secondary P.P.H.	5
Cholecystitis	1	Pain in legs	28	Septic finger	1
Collapse	4	Painful coccyx	1	Severe chill	6
Condition of breasts	32	Perineal pain	1	Severe toothache	1
Congestion of nasal passage	1	Phlebitis	29	Shingles	1
Cystitis	1	Prolapsed Uterus	1	Shock	3
Ear ache	1	Puerperal haemorrhage	1	Subinvolution	4
Eclampsia	1	Puffiness in face	1	Swollen eye	1
Fits	1	Pyelitis	2	Taking of Rhesus specimen	3
General condition	15	Pyrexia	74	Throat infection	3
Haemorrhoids	7	Raised blood pressure	3	Thrombosis	6
Hard labia	1	Rash	6	Tonsillitis	2
Headache and Vomiting	15	Respiratory condition	5	Undefined illness of mother	18
Inflammatory patch on left leg	1	Retention of Urine	1	Varicose Veins	7

THE CHILD (815)

Abscess	1	Feebleness	55	Prematurity	131
Anencephalus	3	Foreign body in buttock	1	Pyrexia	2
Asphyxia	21	General condition	36	Rash	30
Birth injuries	11	Haemorrhage	5	Respiratory conditions	9
Blue baby	8	Hare lip and cleft palate	6	Retention of urine	4
Born before arrival	1	Heart conditions	2	Septic cyst	1
Cephalhaematoma	1	Icterus neonatorum	17	Septic fingers	4
Chest conditions	11	Injection for whooping cough	1	Septic spots	4
Colic	2	Impetigo	1	Severe chill	4
Coryza	2	Jaundice	35	Snuffles	6
Condition unknown	9	Maelena	8	Spasms	1
Conjunctivitis	12	Malformation	49	Spina Bifida	10
Convulsions	9	Marasmus	1	Stillbirth	10
Cyanosis	37	Macerated foetus	1	Swelling on spine	1
Death of infant	3	Oedema	5	Talipes	4
Definition of sex	1	Offensive stools	1	Tongue tie	12
Discharging eyes	167	Ophthalmia	1	Tumour right arm	1
Enlarged glands	1	Pemphigus	9	Unsatisfactory umbilicus	9
Erythema	1	Phimosis	14	Vomiting and enteritis	18
Facial paralysis	3	Post Maturity	1	Yellow Baby	1

Midwives made the following "statutory" notifications:—

(i) Records of sending for medical aid	5435
Deaths of (a) mother	8
(b) child	117
Stillbirths	239
Laying out the dead	71
Liability to be a source of infection	152
Substitution of artificial feeding for breast feeding	801
(ii) Liability to be a source of infection	152
Puerperal Pyrexia	72
Pemphigus Neonatorum and other skin diseases	20
Erysipelas	3
Scarlet Fever	5
Pneumonia	2
Septic abortion	3
Laying out the dead	2
Other cases of infection	45

Gas and Air Analgesia—The approval of the Central Midwives Board to the use by midwives of gas and air machines in the relief of pain during childbirth has allayed the fears of many lying-in mothers. Gradually all midwives are being trained in the use of gas and air analgesia; analgesia was used at 3,280 confinements (261 machines). The mother needs to be completely familiar with the apparatus before her labour begins and midwives now give instruction at the ante-natal clinics.

Ante and Post Natal Services

In a divided health service ante-natal care may be obtained from so many different sources that there is a risk of confusion, which may lead either to overlapping on the one hand, or to oversight on the other. To avoid this the Medical Officer of Health must co-ordinate the arrangements and see that every expectant mother is offered from some source both (i) supervision and teaching, and (ii) medical care.

The relative function of an ante-natal clinic and the care by the family doctor and/or by the hospital is not yet fully appreciated. The clinic can provide continuous supervision and detailed teaching and in this capacity remains a most important institution despite other arrangements for medical care now made available under the Act. Where a private practitioner is

booked, or a bed is earmarked in a hospital or maternity home, the medical care thus afforded does not eliminate or supersede the need for regular supervision and teaching at a clinic. Where mothers attend clinics the general practitioner or hospital must be informed of all material findings at the clinic. There is, in fact, a greater need for the local authority clinic than ever before and it is regrettable that in certain parts of the county some medical practitioners cannot get the ante-natal clinic in a true perspective. 77,198 separate attendances were made by expectant mothers to ante-natal clinics; of the total births approximately 66% of the women in this county attended clinics.

For some time toxæmias have been the cause of much difficulty and damage during pregnancy. In 1949, 165 medical aid notices were issued by County Council midwives for toxæmia. A rise of blood pressure invariably precedes the more obvious signs of toxæmia (such as albuminuria and oedema); this is the time when treatment is most effective. Regular blood pressure estimation can, therefore, do much to prevent the toxæmias of pregnancy, and to make this easier sphygmomanometers have now been issued to all domiciliary midwives (subject to training and proficiency test).

Post-natal Clinics—2,707 attendances by 2,385 women were made at post-natal clinics, representing 9% of the total of women confined. This is a small figure in view of the widespread maternal disablement which results directly or indirectly from child-bearing. Now that the danger of loss of life in childbirth has been so greatly reduced we should be striving increasingly to limit the amount of damage to health and strength and it is certainly time that the post-natal clinic is developed to play a part in this campaign equal to that of the ante-natal clinic in earlier years. There is little doubt that the reduction of maternal disabilities, whilst primarily dependent upon adequate ante-natal care, good conservative obstetrics and proper nursing during the puerperium, could be further reduced by thorough after-care through the post-natal clinic.

The separation of the Maternal Health Service from the Child Health Service—In my report for the year 1947 I outlined a scheme for the separation of preventive obstetrics from preventive paediatrics. This remains unfulfilled for want of agreement by all parties concerned. As last year the example of this in operation at Mexborough remains the only one in the County. The following is a further report on the working of the scheme by Dr. Leiper, Divisional Medical Officer of the Mexborough Division:—

“Dr. Renshaw has continued to conduct most successfully a combined service (in Division 30); he works for the County Council in ante-natal clinics and for the Rotherham and Mexborough Hospital Management Committee as Junior Hospital Officer in immediate charge of the maternity unit at the Montagu Hospital. The total number of births in this division in 1949 was 1,263 (including 17 sets of twins) and 1,246 mothers were confined. 1,159 (i.e., 93%) of these attended County Council clinics (total attendances 5,826, each expectant mother making 5 to 6 visits) giving an average attendance of 500 per month. This is an increase of 25% from last year (average attendance 400 per month). 206 mothers were confined at the Montagu Hospital.

The appointment of Dr. Renshaw in charge of five county ante-natal clinics has proved a key factor in the making of a clinic team. At each clinic the health visitor is present; she is in charge of the clinic, and responsible for the group-teaching of expectant mothers; the domiciliary midwives also make every effort to attend. The selection of the most important cases to admit to the limited beds at the Montagu Hospital has been rendered much easier. There has been a marked increase in the work of the midwives, who followed up with home visitation of the patients in order that advice given at the clinic could be implemented; particular attention being given to diet, vitamin take-up, rest, and general arrangements for the confinement. About five hundred such ante-natal domiciliary visits were made each month by the 13 midwives in the division. I am glad to say that there has been no criticism of the great amount of work carried out in these clinics from general practitioners or other bodies.

The influence of this scheme can be clearly seen in our vital statistics. In 1948 there was a stillbirth rate of 33 per 1,000 live and still births; this has fallen in 1949 to 19.4. In 1948 the infant death rate was 56, and the five-year average 1944 to 1948 was also 56 per 1,000 related births; this has fallen to 41. In 1948 the neonatal death rate was 31; this has fallen to 23.7. The hospital statistics show that of the 206 deliveries carried out in the Montagu Hospital there were 6 stillbirths out of the divisional total of 25 stillbirths for the year. Owing to the small number of births under consideration, variations in these rates will occur, but it can be said that the present trend is favourable and these vital statistics are approaching the national rates.

There was no significant change in the number of primigravida expectant mothers delivered at home during 1948 and 1949.

One of the disadvantages in this combined appointment which unifies the control of the expectant mother group is that the grading of the appointment by the Regional Hospital Board is that of Junior Hospital Officer. The great impact of this appointment on community health deserves, in my opinion, the grading of Senior Hospital Medical Officer, or that of a Specialist in obstetrico-social matters.

In the past, the duty of the ante-natal officer without specialist experience, has been the elimination from the clinic to the care of the general practitioner of those expectant mothers who were clinically abnormal. Since the advent of unified control of the expectant mother group, together with the separation of preventive obstetrics from preventive paediatrics, the policy is now to seed out the clinically abnormal or the potentially abnormal at the ante-natal clinics and book them for hospital confinement, together with a number of other cases in which the home circumstances are poor, leaving only the clinically normal for domiciliary confinement. As an example, breech presentation only occurred three times in 845 domiciliary births in the division in 1949, and in all these three cases the expectant mothers did not make satisfactory attendances at the clinic. Cases of external version were performed at the clinic and those presenting difficulty were referred to the Consultant Obstetrician and Gynaecologist at the Jessop Hospital, Sheffield, and the Montagu Hospital, Mexborough.

There have been additions to the list of general practitioners undertaking domiciliary midwifery in the area during the year; these additions to the list were assistants to principals in general practice. This has raised the problem of ensuring that as many expectant mothers as possible attend the ante-natal clinics of the Health Authority, and of supporting the midwives in their desire to act as such, and not to become purely maternity nurses. Meetings have been held with the practitioners concerned regarding their relationships with the midwives and the position has been cleared satisfactorily; only 34 cases were attended by general practitioners as against 845 delivered by midwives, whilst 93% of all expectant mothers within the division attended ante-natal clinics of the Authority.

The work of a Junior Obstetrician during the year has been very successful and this success is being reflected in the sound improvement in the vital statistics.

In order to obtain the full benefit of this appointment, which unified the control of the expectant mother group and which is such an integral part of the Public Health team in this area, it is thought that one such appointment for an area having 1,200 births per year represents an optimum.

The scheme would be rounded off best by the addition to Dr. Renshaw's appointment of the professional work associated with a flying squad."

Consultant Services—The scheme to cover the whole county with consultant help of a fundamentally preventive character, outlined in my report on Specialists last year, has still been impossible to implement owing to the prevailing uncertainties as to the respective responsibility of Boards and Local Health Authority. In its absence every effort has been made to produce an efficient working arrangement by close collaboration with the Boards' Specialists. In the past it has been the custom of this Authority to make provision for consultant opinion to be given away from hospital, usually in its own consultant clinic premises or the rooms of the consultant. The effect of associating maternity cases with out-patient departments of hospitals creates rather than dispels anxiety at a time when a woman is most prone to emotional influences.

"Flying Squad" Arrangements—The "flying squad" to treat mothers at home when the condition is too grave for removal to hospital, is provided by staffs of the maternity departments of certain hospitals. "Flying squads" are available for use in domiciliary midwifery from any of the under-mentioned hospitals:—

Barnsley	St. Helen Hospital.
Bradford	St. Luke's Maternity Home.
Halifax	Halifax General Hospital.
Harrogate	Harrogate and District General Hospital.
Leeds	Leeds Maternity Hospital.
Sheffield	Jessop Hospital.
Wakefield	General Hospital.

Ante-Natal Hostel—This hostel, situated at Brighouse, has completed its first year of occupation. It is an experiment in preventing abnormalities in pregnancy; all women are not fortunate enough, either mentally, physically or economically, to go through the stress and strain of reproduction without some form of breakdown; the hostel, by taking this type of case, together with those suffering from other minor conditions, such as anaemia, debility, varicose veins, for which rest is essential, can do much to prevent the development of more serious conditions for which treatment in hospital becomes necessary. Admission to the hostel can be effected at any stage of the pregnancy; of the sixty cases which were admitted the average stay was twenty-four days. There are many more cases in the County which would benefit by rest in the hostel, probably many thousands, but the idea must be allowed to grow slowly; the question of cost may be a deterrent, this not being a free service; the lack of a nursery is also a handicap to mothers with young infants who cannot be left at home. Small though the number of admissions may appear the hostel has rendered a most valuable service.

The following report has been submitted by Dr. Appleton, Divisional Medical Officer of the Brighouse Division, on the first year's operation of the hostel:—

"At the Clifton Ante-natal Hostel, the first of its kind in this County, there are few rules and regulations; these are confined to hours of meals and times of prescribed rest. All the patients have their breakfast in bed for the first few days after they are admitted and they are not permitted to miss a meal without a good reason. Apart from that they are very

largely free to go out into the town, to go walking, or to do whatever they wish, a freedom that is very welcome and very unusual for a woman with a family. Visitors are allowed every day and at any hour of the day, and all the women are able to receive direct incoming telephone calls. Generally speaking, all the patients are fully ambulant, although from time to time it has been necessary to prescribe rest in bed.

At present, particularly in the textile areas, there is a tendency for women who are expecting their first baby to continue employment until far too late in pregnancy, and they enter their first labour tired, strained and apprehensive. There is no doubt that the relaxation technique at home does much to ameliorate their condition, but it is often impossible for them to relax efficiently faced as they are with the dual tasks of home management and factory work at a time when exceptional demands are being made on their physical resources by the growing foetus. The young wife has passed from a time when she had only herself to consider and was one of a family who was cared for by her own mother to a woman who is still carrying out her pre-marital occupation with the additional new work of housewifery, and at the same time is encountering the physical and mental changes which are the concomitant of pregnancy. A month's complete rest during this exacting time in an ante-natal hostel where she can have advice and can talk with other women who have had similar experiences may have far-reaching remedial effects. She is often much better resting in an ante-natal hostel where there is freedom of movement and an atmosphere of normality than in hospital or at home where she may have the over-anxious advice of both mother and mother-in-law.

When the second and subsequent pregnancies take place the woman is concerned not only with the care of the house but with the care of her other children and frequently has to ignore signs of fatigue, general malaise and anaemia and is unable to rest when she develops early signs of varicose veins. As time goes on and household cares and strain increase, with no possibility of a break in her routine, she may develop nervous strain, indeed, in some cases the lack of a rest when it is required leads to uncertain temper and even may be a factor in the breaking up of family life. Those with early raised blood pressure respond very well to a few days rest, and this often prevents later hospitalisation. Many early departures from normal can in this way be checked and so prevent serious or permanent damage later and (as a lesser consideration but yet of importance today in our straitened finances) expensive treatment in hospital can be avoided. There are many patients who require rest and supervision during the ante-natal period but whose condition is not sufficiently severe to merit hospitalisation.

These mothers cannot go to an ordinary convalescent home and, in fact, they are not anxious to do so while they are pregnant but in an ante-natal hostel, where all the patients are pregnant at the same time, they are able to enjoy rest and care without being concerned about their appearance. The women are also linked by a common interest and the preparation of baby clothes and the care of the family present topics of conversation and mutual interest. It is believed that many women do better in an ante-natal hostel than they would in a hospital ward or at home.

Many women who need a period of rest in a hostel have other children to care for. It was one of the objects of the two Public Health short-stay residential nurseries (established at Skellow Hall and Harrogate) to accommodate such children and so make it possible for a mother to enter the ante-natal hostel. It has been one of the unfortunate side effects of the Children Act that these two nurseries were taken over from the health department and used for other purposes. Many of the difficulties of operating our new ante-natal hostel have been aggravated by this unfortunate occurrence. As an alternative it was decided to use for this purpose one of the wards of the original hospital selected as a suitable one for conversion.

It was decided to open the hostel using the existing buildings without any extensive adaptation or decoration and the first case was admitted on the 21st September, 1948. Five other cases were admitted in October, one in November and two in December, 1948. In addition we provided temporary accommodation for a woman and baby. One patient suffered from asthma and bronchitis, five from severe varicose veins and oedema, two from anaemia and three had a raised blood pressure. At this time we had not satisfactory accommodation for more than ten patients. During 1949, equipment for the hostel began to arrive and the existing equipment loaned to the County Council by the Brighouse Corporation, most of which was unserviceable, was subsequently disposed of. During the first six months of the year the hostel was for this reason operating under extreme difficulty and in this period only 18 patients were admitted. These patients were suffering from the following complications :—

Varicose Veins and Oedema	...	...	...	8
Anaemia	...	...	...	5
Raised blood pressure	...	...	...	2
Hydramnios	...	...	...	1
Albuminuria	...	...	...	1
Thrombo Phlebitis	...	...	...	1
Bronchitis	...	...	...	1
Twin Pregnancy	...	...	...	1

One of the valuable uses to which the hostel can be put is to admit that greatest of all social problems in the maternity field—the unmarried mother; the first admission of this type was a European volunteer worker from a neighbouring hostel who was having her first child and had nowhere to live.

In the second half of the year 45 patients were admitted, and although the hostel was not yet fully equipped we now had accommodation for 24 patients. Seven of the patients were completely normal and were only admitted because they had no satisfactory homes. One of these women had been evicted from her home and six were unmarried mothers, two of them being European volunteer workers. In the remaining 38 patients the following complications occurred:—

- 15 cases of severe varicose veins.
- 15 cases of anaemia.
- 5 cases of raised blood pressure, all of which settled down with rest.
- 3 cases of oedema. (One patient suffered from gross oedema; this was a case of a twin pregnancy and she was able to go to term with the rest provided in the hostel).
- 2 who had rheumatic disease of the heart.
- 3 who had suffered from vomiting, which settled down very quickly with rest and diet.
- 1 case of rheumatoid arthritis.
- 2 cases of incontinence, in both of whom this was controlled with rest and re-education.
- 1 case of tape worm.
- 1 patient suffering from malnutrition.

One patient was admitted suffering from hysteria. She was extremely worried about her confinement and with rest in the hostel and rehabilitation and instruction in the relaxation technique, she subsequently had her baby after a remarkably short and easy labour. When she was admitted to the hostel she was in an extremely poor mental state. Since her discharge and her delivery she appears to have made a complete recovery and is now a happy and healthy young mother. One patient who was pregnant for the first time was admitted on crutches suffering from functional paralysis of both legs. With rest and re-education, instruction in the relaxation technique and with friendly contact with other patients who had had several children, her confidence was restored and she was able to walk out of the hostel and subsequently had her baby at home without any unusual difficulty. She is now a remarkably good mother, free from anxiety. She faces the future with confidence. Another patient was admitted with Spastic Paraplegia. Her gait improved with rest and relaxation and she subsequently had a normal delivery without instruments. One patient was admitted with a history of three previous pregnancies having ended in abortion. She was a highly nervous subject and very apprehensive about the outcome of this pregnancy. She was subsequently delivered at term of a normal child. One patient was admitted post-natally suffering from severe puerperal depression. She only spent one night in the hostel and had to be transferred the following day to a mental hospital.

Patients have benefited not only from rest but also from contact with one another in an atmosphere which was always cheerful. It is my belief that a patient suffering from neurasthenia or mild depression while pregnant has a far better chance in a hostel among other patients who are also pregnant, where they have freedom of movement, than in a hospital. The homelife atmosphere of the hostel, where many women are enjoying a holiday from household cares for the first time for many years, is particularly useful from a psychological point of view in dealing with the worries and anxieties which undoubtedly exist. We are able, if the women stay a sufficiently long time, to get to know the patients intimately and to discuss their problems with them, and in many cases to interview their husbands and smooth out difficulties. An ante-natal hostel of this kind undoubtedly provides a great contribution to social medicine and has enabled us to obtain a much better insight into homes and families than can ordinarily be obtained by visiting or by the Almoner in a hospital.

Unfortunately we could not obtain Ministry approval to the adaptation of one of the buildings for residential nursery accommodation. Because of the impossibility of providing care for their children during their stay in the hostel, many women have been unable to be admitted and several mothers have returned home before they have had sufficient benefit from their stay because of urgent telephone communications telling them that the arrangements made for their children with friends and relatives have broken down. For the same reason it has not been until very late in pregnancy that many patients have been admitted and they have not had sufficiently long to obtain the maximum benefit. While there is so little short-stay nursery accommodation in the County, the hostel will not be able to fulfil its optimum function until nursery accommodation is provided. The average length of stay has been three weeks but the periods of stay have varied from one day to 75 days. But increasing use is being made of the hostel and already it has proved its value. Women of all classes have been admitted and it is remarkable how well they got on together."

PART IV

CHILD WELFARE

Infant Welfare Centres—There were 211 infant welfare centres operating in the administrative county at the end of the year, at which 458,989 attendances were made (312,464 attendances by infants under one year of age and 146,525 by children between 1—5 years). New centres were opened at Gargrave, Bramhope, Church Fenton, Toekwith, Hirst Courtney and Parkgate. The work of the infant welfare centre is chiefly concerned with education and prevention and most of the common disturbances which are met with are due either to the result of imperfect home environment or inexperience on behalf of the mother. Whilst a number of minor ailments may be treated, they are chiefly those arising from uncleanness and feeding disorders. Mothercraft training and health talks are given at frequent intervals; the medical officer to the centre usually sees each child under one year of age every month excepting those in which progress is of an unsatisfactory nature; breast feeding is encouraged and facilities made available for test feeding of infants when necessary. In a number of centres arrangements have been made for the display of instructional films, whilst in others demonstrations of cooking have taken place. The County Council decided to discontinue the use of "Sunrose" dried milk, a product manufactured on the specification of the County Medical Officer and one which had been supplied for many years. Many of our clinic premises are still not of a standard in which to inculcate health teaching.

Premature Babies—976 babies weighing $5\frac{1}{2}$ lbs. or less at birth were born alive in 1949 (4.7% of live births compared with 4.2% in 1948, 4.3% in 1947, 4.6% in 1946, and 4.0% in 1945). The survival rate for the year was 83.8%, slightly higher than last year. When babies are divided into those born at home and those born in institutions it is seen that improvement over five years in survival of babies in institutions is of the order of about 3%, whereas the improvement in the survival of babies born at home is 10% (72.1% in 1945, 72.3% in 1946, 73.3% in 1947, 82.5% in 1948, 81.7% in 1949). This improvement in the survival of babies born at home is very gratifying and is a testimony to the schemes of care put into operation in our divisions. The chance of survival of babies born at home is now little different from that in hospital and we can no longer categorically say that the place to care for a premature baby is in a hospital. We hope to improve still further our arrangements for domiciliary care.

Most of the infants in the lowest weight groups die during the first day of life and many of them could well grow up to be healthy children. As explained last year every premature birth is now regarded as an emergency and the object is to secure that every baby wherever born is in its specially prepared cot within a few seconds of delivery. When this has been accomplished it is still necessary to nurse the premature baby with devotion, knowledge and skill for many days and sometimes weeks. In some cities specially trained midwives undertake the whole of this work but in a large and scattered county this is not possible. Every midwife must have special training in premature baby care; this is being done at the Sorrento Maternity Hospital, Birmingham, where 56 midwives have already been trained in the last three years. Home nursing of the premature baby, if not ultimately found to be most effective (this is still a subject of study), will certainly be required for most of the premature babies born at home, since removal to hospital is rarely possible. In general, hospital care should be limited to those infants under $3\frac{1}{2}$ lbs. in weight, together with a few of the larger babies with other abnormalities; transfer must then be immediate and by means of a specially heated ambulance, otherwise it will generally be useless. Whether the baby is to be nursed at home or transferred to hospital, the first and most essential need is for every midwife to work closely with the health department; only in this way is it possible for the special equipment (cot or incubator, oxygen, feeding utensils) to be ready and prepared in the mother's home for the reception of the baby and, if necessary, for arrangements to have been made for immediate transfer to a premature baby unit. Success depends upon a team operation (midwife, health department, general practitioner, ambulance department, hospital, children's specialist) with the midwife as the key member.

The three tables which follow give the relevant statistics.

THE FATE OF PREMATURE BABIES BORN IN THE YEAR 1949 IN INSTITUTIONS* IN THE WEST RIDING ADMINISTRATIVE COUNTY

Total unadjusted live births—7,383

Percentage of live premature births—434

Percentage of total live births—5.9

Number born dead—50

Weight group lbs.	No. of Premature Births		Number Dying (Days of Survival)														Number surviving over 28 days	Percentage Survival in 1949	Percentage Survival in previous years.			
			First Week							Second Week												
	Born Alive	Born Dead	1	2	3	4	5	6	7	8	9	10	11	12	13	14			Over 14 up to 28 days			
			—	3	—	1	1	—	—	1	—	—	—	1	—	—				—		
5—5½	224	12	—	3	—	1	1	—	1	—	—	—	—	1	—	—	217	96.9	96.4	91.5	95.0	95.2
4½—5	87	6	3	3	1	—	—	1	—	—	—	1	—	—	—	—	77	88.5	90.5	93.8	92.1	92.0
4—4½	58	14	3	4	—	—	—	—	—	1	—	—	—	—	—	—	50	86.2	70.6	75.6	76.5	86.2
3½—4	24	5	4	—	1	—	—	—	—	1	—	—	1	—	—	—	16	66.7	65.2	64.9	71.4	65.4
3—3½	15	4	—	—	1	—	—	1	—	—	—	—	—	—	—	—	13	86.7	41.2	45.5	52.9	61.1
2½—3	12	3	7	1	—	—	1	—	—	—	—	—	—	—	—	—	2	16.7	37.5	66.7	0.0	25.0
2—2½	8	2	8	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0.0	25.0	0.0	0.0	0.0
1½—2	6	3	4	—	1	—	—	—	—	—	—	—	1	—	—	—	—	0.0	0.0	0.0	0.0	0.0
Under 1½	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0.0	0.0	0.0	0.0	0.0
	434	50	29	11	4	1	2	2	1	1	2	—	2	2	—	—	375	86.4	83.4	81.4	84.6	85.3

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* Hospitals, Maternity Homes and Private Nursing Homes.

THE FATE OF PREMATURE BABIES BORN IN THE DOMICILIARY PRACTICE OF MIDWIVES IN THE YEAR 1949

Table showing survival in the Urban and Rural Districts of the Administrative County

(All the figures in this table relate to births in the domiciliary practice of midwives)

[illegible]

Weight Group lbs.	No. of Premature Births.				Number dying — days of survival (County)														Number surviving over 28 days.			Percentage survival			
	Born Alive.			Born Dead (County)	First Week.							Second Week.							Over 14 up to 28 days	U.D's.	R.D's.	County			
	U.D's.	R.D's.	County		1	2	3	4	5	6	7	8	9	10	11	12	13	14							
5—5½	150	75	225	14	4	2	—	—	2	1	1	—	—	—	—	—	—	—	1	143	70	213	95·3	93·3	94·7
4½—5	98	40	138	10	2	2	1	1	—	—	—	—	—	—	—	—	—	—	1	93	36	129	94·9	90·0	93·5
4—4½	49	23	72	10	5	2	—	1	—	—	—	—	—	1	—	—	—	—	2	41	19	60	83·7	82·6	83·3
3½—4	25	10	35	8	5	4	1	—	—	—	—	—	—	2	—	—	—	—	3	14	5	19	56·0	50·0	54·3
3—3½	21	12	33	10	12	1	2	—	—	1	—	—	—	—	1	—	—	—	—	12	4	16	57·1	33·3	48·5
2½—3	11	9	20	7	11	2	—	—	—	1	—	—	—	—	—	—	—	—	—	3	3	6	27·3	33·3	30·0
2—2½	6	7	13	5	11	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0·0	0·0	0·0
1½—2	2	2	4	—	3	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0·0	0·0	0·0
Under 1½	2	—	2	1	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	0·0	0·0	0·0
	364	178	542	65	54	14	5	3	2	3	1	1	3	3	1	—	1	1	7	306	137	443	84·1	77·0	81·7

Illegitimate Children—There were 1,323 illegitimate births, a slight decline in the figure for the year 1948. The illegitimate conception strikes at the root of community health, which must be built upon the happy family. Every such conception not regularised by marriage is an individual problem in social medicine to secure a full and healthy life for the child and to rehabilitate the mother. Attention to the many details of such cases as early as possible in the pregnancy can do much to prevent the unfortunate consequences to mother and child which have been a feature of our society for so long. The details of this work have been given in other reports. Miss M. D. M. Mitchell, appointed as part of our scheme under S.23 of the National Health Service Act to give attention to this distressing problem, took up duties on the 26th September, 1949. Her initial task was to visit the divisional areas to discuss the problem in the locality; to arrange for routine supervision to be done by the divisional staff; to meet representatives of moral welfare organisations and to discuss with them ways and means of effective co-operation to ensure that equal attention is given to both the physical and moral aspects of the problem without unnecessary duplication. Up to the end of the year she had investigated 35 cases notified from various sources as being in need of special attention. In 12 cases arrangements were made for the girls to be admitted to moral welfare homes, to stay for periods normally of 8 weeks but longer where necessary. 23 cases were the subject of personal visits when help and advice were given.

Day Nurseries

The Day Nursery Service had made satisfactory progress and is now playing a vital part in the social and economic life of the community. No new nurseries were opened during the year; the number of Nurseries remained at 24 as follows:—

Div.	Nursery.	No. of Approved Places		No. of children on Reg. at end of year		Average daily attendance		Approved for Training	
		0—2	2—5	0—2	2—5	0—2	2—5	0—2	2—5
1	Rostle Top Road, Earby	12	28	10	30	10	25	Yes	—
3	Woodbine, Skipton Road, Keighley	12	28	26	19	22	11	Yes	—
3	Victoria Park, Keighley	12	28	19	19	16	16	Yes	—
4	Manor Lane, Shipley	20	30	25	25	18	22	Yes	Yes
4	Windhill, Recreational Ground, Shipley	20	30	12	39	12	31	Yes	Yes
4	Victoria Park, Shipley	20	30	13	36	11	27	Yes	Yes
5	Oxford Road, Guiseley	12	28	8	33	17	23	Yes	—
5	Sunnybank Avenue, Horsforth	12	28	9	31	9	21	Yes	—
5	Whackhouse Lane, Yeadon	12	28	15	24	10	22	Yes	—
5	Sunfield, Providence Street, Stanningley	13	22	16	23	9	24	Yes	Yes
6	The Grange, Burley-in-Wharfedale	12	28	17	25	10	18	Yes	Yes
6	Castle Road, Ilkley	12	28	17	27	13	24	Yes	Yes
6	The Licks, Cattle Market, Otley	12	28	11	29	8	23	—	—
8	Albany Avenue, Harrogate	12	28	9	31	8	21	Yes	Yes
8	Station Avenue, Harrogate	12	28	11	31	10	28	Yes	Yes
14	Lewisham Park, Morley	12	28	10	30	8	22	Yes	—
14	Grove Park, Gildersome	12	28	6	32	6	21	Yes	—
15	Cemetery Road, Heckmondwike	12	28	12	28	11	24	Yes	Yes
16	Queen Street, Stourton	12	28	11	28	11	23	Yes	Yes
17	Moorends, Cleckheaton	12	28	12	22	11	19	Yes	Yes
18	Ogden Lane, Brighouse	12	28	7	37	7	27	Yes	Yes
18	Wellholme Park, Brighouse	12	28	13	34	10	30	Yes	Yes
19	Beech Recreation Ground, Sowerby Bridge	20	30	27	29	19	21	Yes	Yes
19	Feast Ground, Hebden Bridge	12	28	12	30	9	23	Yes	—

The adaptation of The Glen, Todmorden, as a nursery for 40 children proceeds and may be completed in the latter half of 1950. The creche at Pontefract, transferred from Pontefract Corporation under the National Health Service Act (and used mainly for the children of shoppers and for the relief of mothers for leisure) was closed on December 31st.

The 17 nurseries acquired in 1948 from the former autonomous authorities have been successfully absorbed into the County Service. All the day nurseries have been visited by a Sub-Committee and schemes of alteration and adaptations have been approved; decorations and structural alterations have been completed at 6 nurseries. A new standard of essential equipment (including the kitchen and recreational equipment) has been adopted and is nearing completion. The grounds of most of the nurseries are as yet uncultivated and thereby detract from the general appearance of the premises. For many years shortage of staff has prevented our nurseries from achieving the highest standards; but this is being resolved slowly as the County training scheme makes available more trained nursery nurses. The goal in view is the replacement of all untrained staff by trained nursery nurses. There is also a great shortage of teachers for the 2—5 age toddlers and this aspect of the nursery problem, equal in importance to that of the nursery nurse, gives little hope of solution in the absence of training facilities for “wardens.” A nursery warden (the alternative to a qualified nursery teacher) must complete a course of Senior Child Care Reserve type and a supplementary Wardens’ Course. We have now one qualified nursery school teacher and 11 wardens.

Nurseries make an important contribution to the success of social medicine; this is altogether apart from the help given to industry by releasing mothers for essential employment. The nursery helps mothers to care for their children, and sets a high standard of child hygiene; it takes in children from over-crowded and insanitary dwellings where mothers are gravely handicapped, if not wholly obstructed, in their greatest work—progressive development of their children; it attends to health by regular supervision and monthly medical examinations (including immunisation) and by close co-operation with the child's own doctor; it helps the overtaxed home in many other ways, e.g., where there is tuberculosis or other serious illness, and it helps in the rehabilitation of the illegitimate family. The nursery is indeed essential to our modern society.

Provision of Nursery Accommodation for Children of Women Workers—In 1948, on the urgent representations of the Ministry of Health, the County Council approved a plan for the erection of 16 new nurseries, each to provide accommodation for 50 children, as a contribution towards encouraging married women to enter the textile industry and contribute towards the material export drive. Of the 16 nurseries proposed those at Brighouse, Haworth, Holmfirth, Saddleworth and Slaithwaite were abandoned owing to site and/or labour difficulties; those at Elland, Gomersal, Morley, Mytholmroyd, Shipley (Windhill), and Sowerby Bridge, were abandoned (February, 1950) on representations of Ministry of Health in view of the need for material economy in capital expenditure; and those at Baildon, Barnoldswick, Bingley, Keighley and Shipley (Saltaire), are in process of erection.

The rather slender results of this big scheme suggest that there is little immediate prospect of any further expansion of the nursery service, other than that now in progress.

The Training of Nursery Nurses—The work of training students for the examination of the National Nursery Examination Board continues with the use of the training facilities provided by the day nursery service. The training scheme is a joint effort between the Education and Health Departments. Miss Brooks (whole-time health tutor) meets weekly her education colleagues to discuss and arrange— (a) interview with candidates; (b) training nurseries for the students, and (c) welfare of students during training. The course of training covers two years (normally from the age of 16) and consists of— (a) further education in vocational and general subjects, the arrangements for which are made jointly by the Education and Health Departments, the health lectures being given by officers of the Health Department, and (b) practical training in day, residential, and school nurseries. Students must have practical experience in the care of children under five years of age, at all stages of their development. 23 nurseries are approved by the Ministry of Health for practical training in the 0—2 age groups and 14 are approved jointly by the Ministers of Health and Education for practical training in the 2—5 age group. Students are interviewed by a panel of three persons— Miss Mayo (Senior Course Tutor, Education Department), Mr. Armstrong (Educational Psychologist), and Miss Brooks. Students are given intelligence and English tests; an interview and a medical examination (this includes a satisfactory chest X-ray examination).

In 1949, 89 students began training (compare 56 in 1948 and 100 in 1947) in courses arranged as follows:— Dewsbury—23; Harrogate—23; Rotherham (C.B. Course)—16; Sheffield (C.B. Course)—6; Shipley—21. The Ministries of Education and Health agreed to recognise a modified course for students who could not be admitted to nurseries; the number taking this modified course in 1947 was 26, in 1948—0, and in 1949—16. It will be discontinued as soon as possible. Of the 145 students in training 65 took the examination (60 passed, 5 failed), 15 discontinued training because of ill-health or domestic reasons, and 1 was transferred to a nursery school; 9 of the successful students entered hospital to continue with general nursing training.

“One Oak,” Parish Ghyll Drive, Ilkley, (which opened on the 25th October, 1948) is a valuable part of the training scheme. This Centre for student nursery nurses (one of the few in Britain), situated within easy access of a number of day nurseries, houses students who are unable to obtain practical training with the 0—2 age group whilst living at home. Students remain for one year; during this time they travel on three days a week to the day nurseries for practical experience with the 0—2 age group; for the rest of the week students remain at “One Oak” and receive the equivalent of two days’ theoretical training. (Health aspects of Growth and Development, Self Expression, Household Arts, Study of Living Things, Life in the Community, English, Domestic Science).

In this first full year of working of “One Oak” six girls who entered in October, 1948, completed nine months’ training and left in July, 1949; a second set of six girls began in June, 1949, and a further twelve in August, 1949. Thus, the Centre was not used to capacity in 1949; structural alterations continued throughout the year. The Centre is also used for meetings of day nursery matrons, course tutors and students.

Nurseries and Child Minders Regulation Act, 1948

At the beginning of the year three daily minders were registered and during the year registration was approved for the following three Nurseries, established by textile factories, with maximum capacity as shown:—

<i>Address of Nursery.</i>	<i>No. of children.</i>
Mons Mill, Burnley Road, Todmorden	31
South Brook Mill, Mirfield	24
Hall Ings, Honley	30

Two of the nurseries were asked to make certain alterations to their original proposals and these were undertaken satisfactorily before registration was finally approved.

PART V

THE HEALTH OF THE SCHOOL CHILD

Introduction

(This, together with the following part VI on the County Dental Service constitutes the report for the year 1949 on the School Health Service, being the 42nd Annual Report of the School Medical Officer).

The year 1949 has been a year of consolidation and improvement in the School Health Service which is in part due to the stability of staff at the Central Office and in the Divisions where there have been few changes among the medical and clerical personnel and the routine work is, therefore, well up-to-date. While this stability of staff is at present useful, we are living to some extent on our capital of medical manpower and there are very few young men and women coming forward to make a career in public health. Out of 41 Assistant County Medical Officers, 28 are women, 18 of whom are married (2 on maternity leave at present); only 11 have a Diploma in Public Health and several entered our service with less than the customary post-graduate training. This situation is partly due to the fact that higher salaries can now be secured in other parts of the National Health Service. The salary of an Assistant County Medical Officer is now £200 a year less than a school dentist; it is little more than the salary of a junior registrar in hospital and only about a third of the salary offered to a hospital specialist, notwithstanding that the work involved requires a high degree of skill and knowledge certainly not less than that required in many of the hospital specialities. Until this discrepancy is remedied our services must remain at a grave disadvantage.

The importance of this was emphasised in the recent outbreak of smallpox in Glasgow when fatal cases even occurred among unvaccinated medical and nursing personnel. Dr. Laidlaw, the Medical Officer of Health, in his report wrote, "It is of fundamental importance to sustain an efficient public health service of knowledgeable and experienced medical officers, a service still available but threatened with extinction due to failure to recognise preventive medicine as an indispensable element in an integrated National Health Service."

The Medical Inspection of School Children

The supervision of the child's health and progress in school should be comprehensive and continuous, with emphasis on positive health and well-being. The school medical officer must be expert in the field of nutrition, epidemiology, physical medicine, and social and mental hygiene, and have a knowledge of educational matters so that he can advise what special educational facilities are required for the various types of handicapped children. He must be aided by nursing staff with a similar outlook, trained to work in the closest co-operation with both medical and educational staffs, known to the parents as the friend of the family and familiar with the child's environment both at home and in the school. The same doctors and nurses should work in both the school health and child welfare services to ensure continuity of care and a link between the home and school. Continuous supervision of health in schools can best be maintained by the school nurse. Three complete medical examinations during school life, with re-examinations and special examinations (and certain additional examinations during the secondary school life) should be generally regarded as adequate in view of the shortage of doctors. In the intervening periods the school nurse, by regular visits of inspection, can secure that nothing of importance is overlooked. She should pay particular regard to the detection of handicaps, the early defects of vision and hearing, abnormalities of behaviour, and other departures from normal are well within her capacity. Her relationship with teachers and parents should be close and intimate.

The relationship with the family doctor is an important factor upon which the success of the school health service depends. Much is said about the need for general practitioners themselves to undertake medical inspections and it is suggested that the use of whole-time doctors on the staff of the school medical officer will impair the family doctor relationship. It must, however, be recognised that the need for each school to have its own doctor to advise and guide on all matters of health within the school and the need for work to be done in fixed hours and on the school premises (in properly equipped examination rooms), make it difficult for general practitioners to engage in the work. Where they agree to participate they should be prepared to give up at least half their time without conflicting engagements and to take on a fixed range of schools without making distinctions in the event, as is likely, of schools under their care containing children on the National Health lists of other practitioners. School examinations cannot be carried out satisfactorily at either a doctor's surgery or at a health centre, as all the important people who feature in the training and life of the child cannot be present for the examination except at the school. The use of whole-time staff has many advantages and is a practical arrangement, particularly where the doctor covers the whole range of preventive work in child health. The relationship with the family doctor can be cemented in the interests of the child and the family by personal contact, particularly by the health visitor and school nurse and by official communication from the school medical officer. The family doctor must be informed of all matters of significance and his advice should be sought before the reference of a child to specialist clinics.

The numbers of inspections carried out during the year compare favourably with those for the year 1948. There were 64,998 periodic medical inspections and 34,709 special inspections and re-examinations compared with 71,858 and 34,684 for the year 1948. The average number of pupils on the registers (including secondary, technical and nursery) was approximately 224,000.

The following tables give details of the numbers of medical inspections made in the various age groups and the numbers found to require treatment:—

Table I
Medical Inspection of Pupils Attending Maintained Primary and Secondary Schools
(including Special Schools)

A. PERIODIC MEDICAL INSPECTIONS

Number of Inspections in the prescribed Groups

Entrants	26,378
Second Age Group	20,414
Third Age Group	12,750
Total	59,542

Number of other Periodic Inspections	5,456
Grand Total	64,998

B. OTHER INSPECTIONS

Number of Special Inspections	11,867
Number of Re-Inspections	22,842
Total	34,709

C. PUPILS FOUND TO REQUIRE TREATMENT

Number of individual pupils found at periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Group (1)	For defective vision (excluding squint) (2)	For any of the other conditions recorded in Table II A (3)	Total Individual Pupils (4)
Entrants	493	4,333	4,608
Second Age Group	1,719	3,034	4,389
Third Age Group	1,017	1,803	2,631
Total (prescribed groups)	3,229	9,170	11,628
Other Periodic Inspections	552	536	1,185
Grand Total	3,781	9,706	12,813

Table II

A. DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31ST DECEMBER, 1949.

Note: All defects noted at medical inspection as requiring treatment are included in this table, whether or not this treatment was begun before the date of the inspection.

Defect or Disease (1)	Periodic Inspections		Special Inspections	
	No. of Defects		No. of Defects	
	Requiring treatment (2)	Requiring to be kept under observation, but not requiring treatment (3)	Requiring treatment (4)	Requiring to be kept under observation, but not requiring treatment (5)
Skin	913	544	800	96
Eyes—				
a. Vision	3,781	1,878	1,212	906
b. Squint	558	435	208	164
c. Other	338	198	298	68
Ears—				
a. Hearing	253	229	78	94
b. Otitis Media	353	235	130	65
c. Other	195	113	176	102
Nose or Throat	3,012	4,664	858	1,098
Speech	188	264	80	210
Cervical Glands	238	1,651	92	207
Heart and Circulation	330	951	131	296
Lungs	492	1,251	249	311
Developmental—				
a. Hernia	85	105	23	30
b. Other	65	322	31	77
Orthopaedic—				
a. Posture	529	503	81	83
b. Flat foot	945	666	193	137
c. Other	543	658	195	200
Nervous system—				
a. Epilepsy	25	68	24	30
b. Other	140	223	62	87
Psychological—				
a. Development	80	226	102	114
b. Stability	77	186	62	46
Other	1,063	923	1,234	331

B. CLASSIFICATION OF THE GENERAL CONDITION OF PUPILS INSPECTED DURING THE YEAR

Age Groups	Number of pupils inspected	A (Good)		B (Fair)		C (Poor)	
		No.	% of Col. 2	No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Entrants	26,378	9,606	36·42	15,897	60·26	875	3·32
Second Age Group	20,414	6,538	32·03	13,075	64·05	801	3·92
Third Age Group	12,750	5,144	40·35	7,280	57·10	326	2·55
Other periodic Inspections ...	5,456	2,179	39·94	3,083	56·51	194	3·55
Total	64,998	23,467	36·10	39,335	60·52	2,196	3·38

Table III

Infestation with Vermin

(i)	Total number of examinations in the schools by the school nurses or other authorised persons	574,968
(ii)	Total number of individual pupils found to be infested	23,457
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	1,415
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	6

Table IV

Treatment Tables

NOTES

(a) The tables deal with all defects treated, or under treatment, during the year, however they were brought to the Authority's notice, i.e., whether by periodic inspection, special inspection, or otherwise, during the year 1949 or previously.

(b) Owing to the difficulty of distinguishing between cases treated under the Authority's schemes and those treated otherwise, the treatment tables (excluding dental) include all cases known to the Authority to have received treatment, whether at their own clinics or elsewhere.

GROUP I—MINOR AILMENTS (EXCLUDING UNCLEANLINESS, FOR WHICH SEE TABLE III).

(a)											Number of Defects treated, or under treatment during the year
Skin—											
Ringworm—Scalp—											
(i) X-Ray treatment	...	...	...	...	...	...	...	...	...	...	16
(ii) Other treatment	...	...	...	...	...	...	...	...	...	...	94
Ringworm—Body	...	...	...	...	...	...	...	...	...	...	191
Scabies	...	...	...	...	...	...	...	...	...	...	435
Impetigo	...	...	...	...	...	...	...	...	...	...	4,102
Other skin diseases	...	...	...	...	...	...	...	...	...	...	5,306
Eye Disease	...	...	...	...	...	...	...	...	...	...	4,655
(External and other, but excluding errors of refraction, squint and cases admitted to hospital)											
Ear Defects (excluding serious defects of the ear)	...	...	...	...	...	...	...	...	...	...	6,020
Miscellaneous	...	...	...	...	...	...	...	...	...	...	60,966
(e.g. minor injuries, bruises, sores, chilblains, etc.)											
							Total	...	...	...	<hr/>81,785
(b)											
Total number of attendances at Authority's minor ailments clinics	...	...	...	...	...	...	...	...	...	...	163,736

GROUP II—DEFECTIVE VISION AND SQUINT (EXCLUDING EYE DISEASE TREATED AS MINOR AILMENTS
—GROUP I).

	<i>No. of Defects dealt with</i>
Errors of Refraction (including squint)	12,025
Other defect or disease of the eyes (excluding those recorded in Group I)	320
Total	12,345
No. of Pupils for whom spectacles were (a) Prescribed	7,830
(b) Obtained	Not known

GROUP III—TREATMENT OF DEFECTS OF NOSE AND THROAT

	<i>Total number treated</i>
Received operative treatment	
(a) for adenoids and chronic tonsillitis	2,044
(b) for other nose and throat conditions	90
Received other forms of treatment	730
Total	2,864

GROUP IV—ORTHOPAEDIC AND POSTURAL DEFECTS

(a) No. treated as in-patients in hospitals or hospital schools	243
(b) No. treated otherwise e.g. in clinics or out-patient departments	2,437

GROUP V—CHILD GUIDANCE TREATMENT AND SPEECH THERAPY

No. of pupils treated (a) under Child Guidance arrangements	270
(b) under Speech Therapy arrangements	205

Table V

Dental Inspection and Treatment

(1) Number of pupils inspected by the Authority's Dental Officers—	
(a) Periodic age groups	76,820
(b) Specials	4,156
(c) TOTAL (Periodic and Specials)	80,976
(2) Number found to require treatment	52,012
(3) Number actually treated	43,222
(4) Attendances made by pupils for treatment	75,340
(5) Half-days devoted to : (a) Inspection	898
(b) Treatment	12,984
Total (a) and (b)	13,882
(6) Fillings:— Permanent Teeth	40,898
Temporary Teeth	3,444
Total	44,342
(7) Extractions:— Permanent Teeth	8,993
Temporary Teeth	54,888
Total	63,881
(8) Administration of general anaesthetics for extraction	9,510
(9) Other Operations:— (a) Permanent Teeth	17,872
(b) Temporary Teeth	7,628
Total (a) and (b)	25,500

The Care of the Handicapped Pupil

Much of the work of a school health service is concerned with handicapped children, for whom Regulations under the Education Act, 1944, prescribe 11 categories. The successful ascertainment and placement of handicapped pupils requires a prolonged study of the problems involved, and a knowledge of educational principles as well as medical. The value of the Handicapped Pupils Regulations is directly related to the professional skill exercised in their administration. Many children are retained on the register who are, in fact, not handicapped within the meaning of the Handicapped Pupils and School Health Service Regulations, 1945; they are medical cases requiring medical treatment and not special education. Vice versa, there are children not on the

register who would greatly benefit by special education for some physical or mental defect, so that scrutiny of the register and the review of defects in school children must be persistently and carefully carried out in the closest collaboration with the Education Department. The full investigation of cases will also bring the school doctor into close contact with the family doctor on such problems as the treatment and stabilisation of epilepsy, the control of diabetes, the suitable placing of the delicate, and the management of the maladjusted where home conditions and influences are at fault. Special institutions for handicapped children, such as hostels for the maladjusted, schools for the delicate, and the physically handicapped and educationally sub-normal (except for the orthopaedic and rheumatic hospital schools which must be part of the hospital system), should be regarded as within the educational system. The school medical officer and his staff should act in an advisory capacity, being intimately concerned with the admission and discharge of children and providing expert professional advice in the medical aspects of the conduct of the schools.

During 1949 the handicapped pupils register was methodically overhauled and each case was re-examined where any doubt existed about the proper form of education being applied. The number of examinations and re-examinations carried out, 3,163, resulted in 350 cases being removed from the register. Some of these were removed, e.g., epileptics, after they have been investigated by the paediatrician and prescribed suppressive drugs to control epileptic fits. Others, e.g. heart cases, were investigated and found fit for ordinary school and full active life in spite of the fact that they had been considered as invalids since their early childhood. Many infantile paralysis and other orthopaedic cases were also found fit for ordinary school. From the financial point of view, apart from the welfare of the children concerned, this matter is of great importance as it costs approximately £250 per annum to maintain a child at a Special School. Also, children who are retained unnecessarily on the register increase the administrative expenditure on reviewing files, and paying special visits. Every effort is being made to retain the greatest number of handicapped children at ordinary schools by making special arrangements for transport, and by providing special teaching appliances.

The following table gives details of new ascertainments of handicapped pupils and placings in special schools and hostels made during the year, and particulars of the number of children in residence in special schools at the end of the year:—

Category	New Ascertainments	New placings in Special Schools	Total No. attending Special Schools:—		No. Boarded in Homes	No. Attending Assisted Schools	No. awaiting placement in Special Schools	No. receiving Home Tuition
			Day	Boarding				
Blind	5	6	—	36	2	—	10	—
Partially Sighted	32	5	10	22	—	—	47	—
Deaf	18	19	10	109	—	—	21	—
Partially Deaf	12	13	6	46	—	—	17	—
Delicate	232	235	161	101	1	1	201	—
*Physically Handicapped	48	29	6	38	—	3	74	35
Educationally Sub-normal	198	5	12	34	—	2	644	1
Maladjusted	27	23	—	1	29	3	61	—
Epileptic	9	7	—	30	—	—	13	1
Totals ...	581	342	205	417	32	9	1088	37

* Excluding children sent to or awaiting places at Hospital Special Schools.

The total number of new examinations and re-examinations of handicapped pupils made by the school medical officers during the year was as follows:—

Category	No. of Examinations.
Educationally Sub-normal	1,153
Physically Handicapped, Delicate and Diabetic	1,576
Deaf and Partially Deaf	61
Epileptic	82
Speech Defect	30
Maladjusted	192
Blind and Partially Sighted	69
	<hr/> 3,163 <hr/>

The Physically Handicapped Child—The following table sets out in detail particulars of the physically handicapped children in the West Riding at the time of writing:—

Physical Handicap	No. on Register	No. attending ordinary school.	No. attending Special Residential Schools.	No. awaiting placement in Special Schools	No. receiving Home Tuition	No. for whom no arrangements have been made.
<i>Disease of the Central Nervous System.</i>						
Spastic Paralysis	84	27	13	27	11	6
Infantile Paralysis	43	30	4	5	2	2
Encephalitis	5	—	—	4	1	—
<i>Heart Diseases.</i>						
Rheumatic Infections	44	30	6	6	1	1
Congenital Defects	25	14	3	1	1	6
Bacterial Endocarditis	1	—	1	—	—	—
<i>Congenital Deformities.</i>						
Talipes and Club Foot	13	9	3	1	—	—
Other deformities of leg and foot	5	3	1	1	—	—
Deformities of arms and hands	3	3	—	—	—	—
Deformities of ribs	1	1	—	—	—	—
Spina Bifida	6	1	1	1	3	—
Hypospadias and Vessicae Ectopia	3	1	—	—	2	—
Congenital dislocation Hip ...	11	3	4	—	—	4
Absence of Rectum	1	—	—	1	—	—
Pseudo Hermaphrodite	2	1	—	—	1	—
Multiple congenital deformities all limbs	1	—	1	—	—	—
<i>Diseases of Bone.</i>						
Tuberculosis of Spine	6	3	—	—	1	2
„ „ Hip	8	6	—	2	—	—
„ „ Knee	5	4	1	—	—	—
Osteomyelitis	6	3	1	2	—	—
Achondroplasia	1	—	—	1	—	—
Avascular Necrosis, Head of Femur	1	1	—	—	—	—
Perthe's Disease	23	19	4	—	—	—
Kohler's Disease	1	1	—	—	—	—
Kyphosis and Scoliosis	3	1	1	1	—	—
Osteochondromata	1	1	—	—	—	—
<i>Diseases of Muscles.</i>						
Progressive Muscular Dystrophies	11	4	—	1	3	2
<i>Blood Diseases.</i>						
Haemophilia	2	—	—	—	2	—
<i>Accidents.</i>						
Ruptured Spleen	1	—	—	—	1	—
Ruptured Kidney	1	—	—	—	1	—
Extensive Burns	2	—	1	1	—	—
<i>Others.</i>						
Arthritic Knee	3	1	1	—	—	1
Still's Disease	6	1	2	2	—	1
Hodgkin's Disease	1	—	—	—	1	—
Hirschsprung's Disease	1	—	—	1	—	—
Celiac Disease	1	—	—	1	—	—
Renal Rickets	2	—	—	—	1	1
Epidermolysis Bullosa	1	—	—	—	1	—
Hydrocephalus	3	—	—	2	1	—
Septicemia	1	—	1	—	—	—
	339	168	49	61	34	26

In addition to the above there were 8 children with double or triple defects, the major defect being physical, and of these 2 were attending ordinary school, 1 was in a residential special school, 1 was receiving home tuition, 3 were awaiting admission to residential special schools, and no arrangements were contemplated in respect of the one remaining case.

Physically handicapped children, grouped under one heading in the Handicapped Pupils Regulations, are of many types and require a variety of educational provision, depending on their medical condition; e.g. children with tuberculosis require education in sanatoria, and children with orthopaedic, cardiac, or a variety of other medical or surgical conditions, may require prolonged periods in hospital where their education must be continued. These children are provided for in hospitals under the Regional Hospital Boards and they are included in the above table.

Children who do not require hospital treatment may be unable to attend ordinary school because they are suffering from some intractable condition which keeps them in bed, or because their home is too far away from any suitable day school. Such children require education at a boarding school for cripples. Again, some children with severe handicaps may not be physically fit enough to stand the rough and tumble of ordinary school and they can sometimes be placed with advantage in a day open-air school, where more individual supervision and care can be given.

During the past year the physically handicapped category has been reviewed and separated into the various types of diseases from which the children are suffering. The spastic child heads the list numerically and is dealt with under a separate heading, but it should be noted that the discrepancy in the figures is due to the fact that the separate spastic table shows all spastics, whereas the physically handicapped table shows only those on the handicapped register as needing special schooling. The figures for infantile paralysis are fairly satisfactory, only 5 are awaiting admission to special schools and the small total of 43 ascertained cases on the register shows that a very large percentage of children affected in the 1947 epidemic are now in a satisfactory physical condition and at least are able to lead a normal school life.

Heart Diseases are divided into two main categories, the rheumatic infections and the congenital deformities. The situation here is again fairly satisfactory, although there are 6 rheumatic heart cases still awaiting admission to special schools. The investigation and ascertainment of heart disease in school children is now most important in view of the great advances in operative treatment both for congenital defects and more recently still for freeing valves damaged by rheumatic infections. Dr. Harvey has dealt fully with this in his report on the Paediatric Service, but it should be added that an arrangement with the Rheumatic Research Centre at Harrogate for the admission and diagnosis of early rheumatic cases has been in operation for nearly a year and has been of considerable help both in the diagnosis and treatment of cases.

There are no other specific illnesses in the table which call for special comment but it is, perhaps, appropriate to refer to the fact that there are 34 cases receiving home tuition. Each case recommended for home tuition is carefully reviewed before the recommendation is made to the appropriate Committee and the number of recommendations is kept down to the absolute minimum. Children of normal intellect who will never be able to walk, (e.g. being completely paralysed from the waist down by tuberculosis of the spine or congenital defect) and particularly all children who are completely bed-ridden, (e.g. with severe heart defects), should at least be taught to read and write. There have been cases of spastic paralysis and other cases where a degree of mental retardation has been present, and some of these cases have received home tuition in the past. These cases present a peculiar problem owing to difficulty in obtaining suitable teachers and in deciding whether the children derive any real benefit from the tuition.

The Spastic Child—The arrangements for the education of this category of handicap are very inadequate throughout the country as a whole. These unfortunate children who are crippled, often mentally retarded, and who may have difficulty in speaking, hearing, or seeing, manage as best they can in ordinary schools. If they are quite unsuitable to attend, some may be given home tuition for a few hours per week; the remainder are left at home under the care of the parents with no educational facilities at all. Particulars relating to *educable* spastics are shown below. The figures do not include children in the ineducable group, who have been notified to the Mental Health Committee as mental defectives.

Total No. of Educable Spastics.	Number accommodated in suitable special schools.	No. attending ordinary school.	No. receiving Home Tuition	No. receiving no education.
213	28 *	84	11	90

* Accommodated as follows:—

Palace School, Ely	1
Braithwaite Open-air School, Keighley	3
Lister Lane Special School, Bradford	2
Pinderfields Hospital School, Wakefield	5
Marguerite Hepton Memorial Hospital, Thorp Arch	3
Halliwick Cripples Home for Girls, Edmonton	7
Open-air School Brighouse	3
Open-air School, Todmorden	1
Chipping Norton National Children's Home	1
W. J. Sanderson Orthopaedic Hospital School, Gosforth	1
Ian Tetley Memorial Home, Hampsthwaite	1

The care of the spastic is best carried out in a special school for the purpose. A very large percentage suffer from double defects and some from triple defects. The teachers in the schools must be selected because of their interest in the subject and their understanding of the difficulties involved in the teaching and care. Additional staff, such as physiotherapists, will be required either whole or part-time. 90 children in this County alone are receiving no education and little remedial treatment, and a large percentage of the 84 attending ordinary school are deriving little benefit there. The opening of a large spastic school would, however, be a very heavy commitment for any single Local Education Authority to undertake at the present time; about 150 children in all could benefit from this type of schooling. On the other hand, provision for delicate and other types of physical handicap is urgently needed and should have priority over the spastic school, which obtains very much slower results and is to some extent provided for humanitarian reasons.

The Epileptic—Special arrangements have been begun during the year to care for the epileptic, the object being to study the circumstances of each case and by help and guidance to prevent many of the evil consequences of the malady. We have as yet no exact information of the number of epileptics in the West Riding but it does not probably fall far short of 2,000, excluding a large number of mental defective epileptics in institutions. The most profitable approach to the problem seemed to us to be through the school child and the adolescent, when rehabilitation can be most effective. Dr. Turner and Miss Carey have jointly taken on this work in collaboration with the Divisional Medical Officers. A survey has revealed 247 educable epileptic school children, of whom 44 are "Handicapped" in the epileptic category of the Handicapped Pupils Regulations of 1945; that is, in need of education in a special residential school. Arrangements are being made for all uncontrolled cases to be seen by a Paediatrician for an estimate of the dosage of sedative drugs appropriate to the case, and, where necessary, teachers, parents, and the family doctor are interviewed. Every child leaving school is followed up through the Youth Employment Service and Disablement Officer of the Ministry of Labour; prospective employers are interviewed and the child is visited during the early stages of employment. A special effort is made to explain the circumstances to employers and shop foremen and, where necessary, to work-mates, in an effort to dispel misunderstandings as to the nature of the malady and to secure that congenial atmosphere in which attacks can be warded off or regarded in their true light of harmless incidents. By these methods it is hoped to prevent a great many epileptics from becoming "substantially and permanently handicapped" persons requiring help under the National Assistance Act.

The following case-notes illustrate the value of the work:—

F.S. Epileptic fits first noticed in 1946 at age 13. Later excluded from school because of frequency of attacks. Treatment arranged with general practitioner and ascertained as requiring special educational treatment. Parents refused to allow him to go to a special school and stated fits less frequent. Parents' opposition eventually overcome and boy admitted to special school in January 1948 at age 14. Having been controlled, he remained fit free and progressed favourably until withdrawn by parents against advice a year later to commence work in father's business. Boy's condition rapidly deteriorated, fits re-occurring at the rate of four per day. Visits made by Miss Carey. Parents regretted their action in removing the boy from special school and agreed to his admission into a mental hospital as a voluntary patient for a period of six months, where he will receive regular treatment for his epilepsy.* If fit on discharge efforts will be made to obtain re-entry to epileptic colony for training for suitable occupation. Youth Employment Officer informed.

* Interim report from Hospital after 3 months shows he is already much better.

The Educationally Sub-normal Child—The largest category of handicapped pupils is the educationally sub-normal group and the anticipated opening of three special residential schools in January to March, 1951, is welcome news. Meltham Mills, nr. Huddersfield, will have 54 places for senior girls; Baliol, Sedbergh, 52 places for senior boys; and a mixed junior school at Springfield, Horsforth, nr. Leeds, will have 60 places. A large percentage of educationally sub-normal cases do not, necessarily, require special residential schooling. It is intended to advise the Education Committee to take a fairly large number of educationally sub-normal cases with slight maladjustment, who require the regularity and discipline of a boarding school. Other educationally sub-normal cases, who may be able to resume ordinary school after 1 to 2 years special teaching in an E.S.N. School, will also be admitted, as well as the straightforward case which may require special teaching during school life. When the schools have settled down after a year or so, it may be possible to increase the maladjusted E.S.N. (and the E.S.N. who will benefit quickly), at the expense of the third group, children in which may be educated in special classes at day schools.

The Blind and Partially Sighted Child—These categories are fortunately numerically small, but there is still difficulty in getting children placed and 10 blind and 47 partially sighted children were awaiting placement at the end of the year. The problem of educating the partially sighted child is especially difficult for County Education Authorities to tackle. The large County Boroughs educate their cases in day special schools, which is a very satisfactory solution, but this Authority finds itself with 47 children to educate, their age range 5—16, and scattered uniformly throughout the County, the greater proportion out of travelling distance of one common centre. Again, one residential school cannot easily meet the educational requirements of the 5—16 age grouping, unless it is very large with a complete range of classes. Arrangements have been agreed among the Regional Education Authorities that one County Borough should provide these facilities. The problem is pressing and some interim arrangement may have to be considered if the long waiting period is to be reduced to reasonable limits. In the meantime, each partially sighted case is, wherever possible, being educated at an ordinary school by special teaching and provision of special equipment.

The Deaf and Partially Deaf Child—Children in these categories are being placed in appropriate schools rather more easily than the partially sighted, but there is still some difficulty in getting them placed quickly. It is not recommended that a special school for either deaf or partially deaf should be considered by this Authority at the present time.

The Delicate Child—Children who have anaemia, debility, rheumatic conditions such as chorea, and chronic non-tubercular lung conditions, are classified in this category and many are only temporarily below par. The study and care of the delicate child is one of the most profitable fields of preventive medicine, as early recognition and prompt action can often halt the progress of the disease. Slight lung infections during whooping cough or other acute infections may progress to bronchiectasis or "cavity" of the lung if the child is not being properly cared for and the sequel

may be hospital for prolonged investigation and ultimately the affected lobe of the lung may be removed. All this is most distressing to the child and is an exceedingly expensive business for the Regional Hospital Board concerned. Many of these conditions can be prevented by adequate nutrition, regular hours of sleep in properly ventilated bedrooms, and suitable clothing.

The Health Visitor can play an important part in the ascertainment of delicate children and the head teacher is often another source of reliable information. The Authority's Special School for the Delicate at Ingleborough Hall, Clapham, is now accepting up to 50 delicate children and the improvement in their mental outlook and physical condition at the end of two terms should be enough to convince the most "Doubting Thomas" that children need regular hours of work and play, fresh air and good food, and if this could be universally obtained in the home, the need for Special Schools and hospital beds would decrease as rapidly as the need for fever hospital beds has done during the past ten years. The time must soon arrive when the efficiency of the social services will be gauged by the number of delicate schools, convalescent homes and hospital beds which have been closed through lack of patients.

At the present time Ingleborough Hall cannot accommodate all these urgent early cases and there is a lengthy delay in obtaining their admission to special schools belonging to other Authorities. During the waiting period many children get progressively worse and when they are finally admitted a prolonged stay is required before they are fit for normal school life. In order to deal with this problem the County Council in October, 1949, accepted financial responsibility for the provision of convalescent home treatment for these cases. During the year 116 cases were admitted to suitable Homes, the average stay being one month, and the majority of the children were subsequently fit for ordinary school after discharge. They have been followed up at the school clinic and by the school nurse and, with the necessary attention to diet, clothing and home conditions, have progressed favourably. It is hoped to admit some more of these cases into the new Schools for Delicate Children, such as Ingleborough Hall, when places are more readily obtainable.

The School Ophthalmic Service

Arrangements for the refraction of children by the Authority's four whole-time oculists and part-time ophthalmologists were continued as in previous years. Children were seen almost immediately after being referred from the school medical inspections or other sources, and delay occurred in few instances only. In these cases the waiting lists were quickly reduced by drafting one of the other oculists temporarily to the areas concerned. 12,025 cases were examined during the year compared with 10,755 in 1948. Spectacles were prescribed through the Supplementary Ophthalmic Services in 7,830 cases. We are still unable to obtain an accurate record of the number of children who received spectacles. The only method by which the Authority can obtain this information is by laborious follow-up work on the part of the school nurse, involving numerous additional visits to either the schools or the children's own homes. This problem is urgently in need of solution and when the ophthalmic service is eventually transferred to the Regional Hospital Boards, the various Hospital Management Committees should be in a better position to furnish the Authority with this very necessary information.

Although information as to when spectacles were received was lacking, it was realized from the number of complaints received that the lengthy delay between the time glasses were prescribed and actually received, which was evident during 1948, still obtained although an improvement was noted in the supply of glasses to priority myopic cases. In an attempt to assess the true position, a random survey was carried out of 148 children who had been prescribed glasses at some time during the year with the following result:—

Total number of cases investigated:—148.

	Number	% of Total Cases
Spectacles received within 3 months	41	27.7
" " " 3 to 6 months	27	18.2
" " " 6 to 9 months	28	18.9
" " " 9 to 12 months	7	4.7
" " " 12 to 15 months	3	2.3
" not received	42	28.3*

* This does not necessarily indicate a waiting period of over 15 months as at the time the survey was made a short time only had elapsed in many instances since spectacles were prescribed.

Speech Therapy

The unsatisfactory position of the speech therapy service due to the acute shortage of speech therapists, and of which mention was made in my Report for the year 1948, has remained unchanged, except for the addition to the staff of a part-time therapist, the total staff at the end of the year being 3 part-time (one unqualified) and one whole-time (unqualified). The number of children treated during the year was only 205. At the time of writing, plans are being made for the establishment of a comprehensive service from September, 1950, when 8 of the students at present completing their training under special awards made by the County Council are expected to take up duty.

Child Guidance

The modern approach to child guidance requires the services on the staff of the school medical officer of a child guidance psychiatrist, and psychiatric social workers, with the assistance of a psychologist; the latter can be on the staff of the school medical officer or, where engaged in educational psychology, may be seconded to the child guidance work from the staff of the Education Officer. Child Guidance Centres must be regarded as a part of a wider system for guiding parents in child management, in which school teachers, school nurses, and school doctors must play their part. The Centres should be concerned with children who have been referred through the school medical officer if they are to maintain a high level of efficiency. Unfortunately, it was still not possible to make a satisfactory appointment to fill the vacancy in the establishment for a psychiatrist and the majority of cases have, as in previous years, been ascertained at the Barnsley Child Guidance Clinic by Dr. Mary MacTaggart, the Corporation's Psychologist. The total number of pupils referred to all clinics for examination and/or treatment during the year was 270.

Hoober House Hostel for Maladjusted Girls has continued its excellent work during the year. Most of the children have been satisfactorily re-adjusted within one year of admission and it is hoped to provide the services of a psychiatric social worker in the near future who can remedy home conditions during the child's absence and supervise the child in its home after discharge from the Hostel. This work is at present being attempted by health visitors but, owing to their many duties and the special type of follow-up work for which special training is necessary, the need for the social worker is urgent and will increase the effectiveness of the Hostel service.

During the year, Oak Bank Hostel for Maladjusted Boys was opened at Keighley. This Hostel was very urgently required as the percentage of maladjusted boys requiring Hostel placement is much higher than girls. Already the Hostel has proved its worth and the increase to 19 places will be a considerable help. The Hostel is designed to give its best results for children at a sufficiently early stage of maladjustment to allow recovery before serious damage has taken place. When the Hostel opened the Education and Children's Committees had some older boys who had been before the Courts and for whom the only alternative was an Approved School. These boys were accepted as a matter of urgency; they are now, on leaving school being placed in nautical training establishments and other suitable careers. This has made it possible to admit less severe forms of maladjustment and delinquency. Among other advantages, this will lead to a greater turnover of cases and increase the value of the Hostel as a weapon to combat juvenile delinquency among maladjusted pupils.

Medical Treatment at Hospitals and Elsewhere

As part of the Authority's arrangements made under Section 48 of the Education Act, 1944, for the medical treatment of school children, the following clinics were in operation at the end of the year:—

<i>Type of Clinic.</i>	<i>Number.</i>
Minor Ailment	162
Ophthalmic	76
Speech Therapy	7
Orthopaedic Treatment Centres	32
Ultra Violet Light	28
Paediatric	19
Chiropody	1
Consultant E.N.T.	22
Consultant Orthopaedic	17
Consultant Dermatology	1

The Consultant E.N.T. and Orthopaedic Clinics have continued to be held either in the Authority's clinic premises or as special sessions in hospitals with a health visitor in attendance at each clinic. Comment is made in a subsequent part of this Report on the general question of the provision of specialists for work in the School Health Service.

The following tables give details of the year's work of the Ear, Nose and Throat, Orthopaedic and Paediatric services:—

Ear, Nose and Throat Consultant Service

CONSULTANT CLINICS.	Number.		
1. Sessions held during the year.	303		
	<i>Pre-school.</i>	<i>School.</i>	<i>Total.</i>
2. No. of individual children referred.	168	3,422	3,590
3. No. of (2) above—			
(a) referred for operative treatment.	91	1,973	2,064
(b) who obtained operative treatment.	71	1,108	1,179
(c) treated at school clinics.	5	358	363
4. Total number of attendances at consultant clinics.	167	4,105	4,272

Orthopaedic Service

A. CONSULTANT CLINICS.		Number.		
1. Sessions held during the year.		402		
		<i>Pre-school.</i>	<i>School.</i>	<i>Total.</i>
2. No. of individual children referred.		675	1,708	2,383
3. No. of (2) above—				
(a) recommended operative treatment (short stay).		15	77	92
(b) who obtained operative treatment.		11	58	69
(c) recommended long-stay hospital school.		—	11	11
(d) recommended treatment by orthopaedic nurse or physiotherapist at treatment centres or at home.		288	656	944
4. Total number of attendances at consultant clinics.		1,138	3,556	4,694
B. TREATMENT CENTRES.				
1. Total number of children treated (including cases continuing treatment from previous year).		999	1,947	2,946
2. Total number of attendances.		6,027	17,074	23,101
C. DOMICILIARY TREATMENT.				
1. Number of children treated.		71	34	105
D. SURGICAL APPLIANCES.				
1. Number of appliances recommended.		66	215	281
2. Number of appliances obtained.		66	201	267

Paediatric Service

CONSULTANT CLINICS.		Number.		
1. Sessions held during the year.		129		
		<i>Pre-school.</i>	<i>School.</i>	<i>Total.</i>
2. No. of individual children referred.		158	540	698
3. Total number of attendances.		241	664	905

The following table gives details of the various types of defect or disease for which children were referred for consultant opinion:—

<i>Defect or Disease.</i>										<i>Number of Children.</i>	
										<i>Pre-school.</i>	<i>School.</i>
Central Nervous System	...	...	...	...	...	...	...	...	...	7	12
Heart	...	...	...	...	...	...	...	...	...	8	137
Chest	...	...	...	...	...	...	...	...	...	4	61
Speech Defect	...	...	...	...	...	...	...	...	...	2	10
Muscles	...	...	...	...	...	...	...	...	...	—	5
Skin	...	...	...	...	...	...	...	...	...	5	10
Psychological	...	...	...	...	...	...	...	...	...	18	30
Ear, Nose and Throat	...	...	...	...	...	...	...	...	...	1	15
Orthopaedic	...	...	...	...	...	...	...	...	...	1	6
Mental Defect	...	...	...	...	...	...	...	...	...	5	9
Congenital Deformities	...	...	...	...	...	...	...	...	...	4	1
Digestive Diseases	...	...	...	...	...	...	...	...	...	3	16
Epilepsy	...	...	...	...	...	...	...	...	...	2	16
Acute and Chronic Rheumatism	...	...	...	...	...	...	...	...	...	—	8
Chorea	...	...	...	...	...	...	...	...	...	—	9
Migraine	...	...	...	...	...	...	...	...	...	—	7
Obesity	...	...	...	...	...	...	...	...	...	—	10
Debility	...	...	...	...	...	...	...	...	...	6	5
Diabetes	...	...	...	...	...	...	...	...	...	8	1
Tubercular Glands	...	...	...	...	...	...	...	...	...	—	9
Hypothyroidism	...	...	...	...	...	...	...	...	...	—	1
Thyroid	...	...	...	...	...	...	...	...	...	1	2
Malnutrition	...	...	...	...	...	...	...	...	...	29	34
Other	...	...	...	...	...	...	...	...	...	54	126

Diphtheria Immunisation

Particulars relating to the number of school children immunised during the year and the immunisation state of the population of children of school age will be found in the section of the Report dealing with Epidemiology. The schools have continued to play their essential role in furthering this valuable work and I wish to express my thanks to all teachers for their collaboration.

The Social Work and Follow-up of School Children

The co-operation between the school doctor, the family practitioner, and the hospital, to secure a comprehensive school medical record is of importance throughout the child's life, and especially at school leaving age and for the next three years when settling in industry and probably requiring the help and guidance of the Youth Employment Service. Unfortunately, the difficulty of obtaining reports from hospitals, as mentioned in my Report for the year 1948, is still with us. The teaching hospitals, realising the need and value to the patient of this information being in the hands of the Local Education Authority responsible for the child's welfare at school, are co-operating very well, but the smaller hospitals are, in general, still disinclined to supply the necessary information. It is important, for example, that a record should be available of the discharge of a child who is in danger of becoming blind through congenital syphilis. (This happened during the year and only came to notice by accident). There must also be many children discharged from hospital ear, nose and throat out-patient departments who are partially deaf and not gaining maximum benefit in school, and of whom the Local Education Authority knows nothing. One ophthalmologist appointed by a Regional Hospital Board to examine school children, refused to disclose his findings to the School Authorities. This causes great difficulty in ascertaining partially sighted and blind children, which is a statutory responsibility under the 1944 Education Act.

A very good relationship is now being built up with the County Youth Employment Service and the recent transfer of the Service from the Ministry of Labour has been most valuable in this connection. A closer working relationship with hospitals and general practitioners is, however, essential to secure that medical findings are translated to the child's advantage in its education and future career in life. The general arrangements for follow-up and after-care of hospital cases are dealt with in another section of the Report.

Cleanliness

The incidence of infestation by head lice shows a slight decline from the 1948 figure, but it is still too high when one considers the ease with which infestation can be dealt with by the latest insecticides. More propaganda is needed both among the general public and, indeed, among medical and nursing personnel, many of whom do not yet appreciate the mode of action and the effectiveness of these preparations.

There were no prosecutions during the year for failure to cleanse, the informal notice having the desired effect in most cases. In some instances, however, the health visitor carries out a family cleansing when this is necessary, owing to the low level of intelligence or for other reasons.

It was necessary to issue an order on the parents in six cases.

Nutrition

There was little change in the general condition of the school children as compared with the years 1947 and 1948, comparative figures being as follows:—

Year	Total number of pupils inspected	Classification					
		A (Good)		B (Fair)		C (Poor)	
		No.	% of Col. 2	No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1947	50,277	19,497	38·8	28,343	56·4	2,437	4·8
1948	71,858	26,077	36·3	41,876	58·3	3,905	5·4
1949	64,998	23,467	36·1	39,335	60·5	2,196	3·4

The average daily number of meals given to school children during 1949 was 128,278. Particulars relating to the supply of milk to school children can be found in the section of the Report dealing with Environmental Hygiene.

A report on a special investigation into the advisability of issuing halibut or cod-liver oil capsules to school children in place of liquid oil will be found at the end of the Report.

Provision of Specialists for the School Health Service

It was recorded in the Report last year that although detailed schemes had been agreed by both the Leeds and Sheffield Regional Hospital Boards for the provision of an adequate service, nothing of advantage had taken place.

The present position is that some of the specialist services are not as effective as they were before the National Health Service Act came into force. This is particularly true of the Ear, Nose and Throat Service. The West Riding had a fairly good Ear, Nose and Throat Consultant Service prior to the 5th July, 1948. It was organised on a divisional basis with a consultation centre in each division (in four cases one clinic served two divisions). Some of the clinics were held at hospitals as special sessions and some in our own clinic buildings. All the administrative side of the clinics was organised by the Divisional Health Offices and a health visitor attended the consultation sessions to act as a link with the home and school. The records all returned to the Health Office and formed part of the child's health dossier.

The Regional Hospital Boards have in the main continued the service. The Divisional Health Office has continued to do the administrative work and the clinics have continued to be staffed by a health visitor. The Hospital Boards, in effect, have done little more than take over the liability to appoint and pay the specialists. Nevertheless, difficulties have arisen (and are tending to do so more frequently) in relation to the specialist himself and the location and character of the clinic. The Boards have changed the specialists to suit their own plans with the result that some carefully selected persons with a leaning towards the preventive work are no longer in the scheme. More serious than this is the fact that some specialists do not appear to feel an obligation towards our service; clinics appear to be regarded as of secondary importance. Where the clinic was operated as a special session in an out-patient department there is, in some instances, a continuous pressure (generally from the specialist himself) to transform this into a mixed general out-patient session and where the clinic was operated in one of our own health centres there is a similar pressure from the specialist to amalgamate the work with the out-patient work of the hospital which he attends. In two divisions we have been deprived (I hope only temporarily) of the service which we had before. It is obvious that we shall have difficulty in maintaining a service of the type and scope envisaged before July, 1948.

It is difficult to give an overall indication of the length of delay before children are seen or, alternatively, admitted to hospital. In the case of children waiting to be seen by the specialist, the delay varies between one week and two years, and for admission to hospital from one month to two years.

Although I have reported adversely on the Ear, Nose and Throat Service, I would like to add that the Consultant Orthopaedic Service, which we had before the 5th July, 1948, has been fully maintained and even extended in some areas by the provision of additional clinics. The ready co-operation of the specialists has been most gratifying.

School Premises

The design and siting of school buildings is left very much to the discretion of the architect and the medical officer is at present usually consulted on minor matters about medical inspection rooms, rest rooms, etc., only. He should have very much more say in the siting and design of schools.

Special Investigations

Issue of Cod Liver Oil Capsules to School Children—For some years liquid cod liver oil was regularly issued daily to school children of 5 years of age and under to provide additional vitamin A and D lacking in the diet of children during the war years and since. The method of administering the liquid oil by teaspoon was frequently criticised by teachers as being unhygienic and messy, and further the oil was refused by the children. The matter was considered at a meeting of the Canteen Sub-Committee of the Education Committee in 1947, when it was agreed to give cod liver oil capsules a trial, and this trial took place at the Penistone Grammar School. At the conclusion of the trial the following report was made jointly by Dr. C. C. Harvey, the Specialist in child health, and Dr. J. Main Russell, Divisional Medical Officer, as a direct result of which the County Council in January, 1949, agreed to a change from liquid oil to halibut oil capsules. During term one capsule is given daily to every pupil up to and including the age of 7 years, and for pupils over this age only on the direct recommendation of the school medical officer.

“QUESTIONS RAISED

- (1) Is cod liver oil regarded as a food supplement merely in virtue of its vitamin D and A content, or for its fat calories value as well?
- (2) Is cod liver oil (or vitamin D and A concentrates) necessary for ALL school children, or only for cases selected on medical grounds?
- (3) Dependent on the answer to question 2, is cod liver oil (or vitamin concentrates) to be treated as a food supplement or as a medicine, when used for school children?
- (4) Is the bottle-and-spoon method of administration of cod liver oil satisfactory in its operation in schools?
- (5) Would a method of administration in schools by capsules prove more satisfactory in achieving the purpose of its use?
- (6) Even if more satisfactory in the short-range objective, would a capsule method engender any undesirable mental attitude in growing citizens for the future?
- (7) Is this whole discussion and trial of methods reaching the ideal for national nutrition.

THE PENISTONE EXPERIMENT

HISTORY—During the early '30s Penistone was a depressed area. The works were shut down, and there was much unemployment and real distress. At that time the Head Master of Penistone Grammar School became concerned about the physique of the boys, and to some extent the girls attending his school. He appealed to the School Governors for help, and so far as we could gather, the Education Authority provided cod liver oil as a supplementary food for these children. Twice a day the children lined up in the Domestic Science Room, where the teacher of Domestic Science doled out a teaspoonful of cod liver oil to each. The Head Master informed us that form

masters and mistresses helped, but at the best it was a messy job. Some children who obviously disliked the oil only took the minimum off the spoon, whilst some displayed nausea for varying periods afterwards. The spoons had to be boiled in soda and involved a lot of tedious work. This experiment went on for $2\frac{1}{2}$ years and the benefits were there—indefinite maybe—but in the opinion of the Head Master “the children appeared to be better.”

About a year ago the Head Master had reason to believe that the older boys in this school were not up to normal physical standards, and I understand the School Medical Inspector supported this view. It was agreed by the County Authorities that a supply of cod liver oil capsules should be supplied for use in the school, more or less as an experiment. These capsules—halibut liver oil—each containing 4500 I.U. Vitamin A and 450 I.U. Vitamin D were given to a selected number of boys from the middle forms—those whose physical condition seemed to demand it; each child received three capsules a day, and was given each Friday evening six capsules for Saturday and Sunday. Similarly, holiday periods were covered. The capsules were taken in the form-rooms—one at 9.30 a.m., one with the mid-morning milk, and one just when classes were resumed after the dinner break. The report of the Head Master was that this taking of capsules involved no time or trouble. The children swallowed the capsules at once and it was all over and done with. The first day of the experiment two children complained of difficulty in swallowing them, but by the third day there were no more complaints. The children continued to receive these capsules up to the end of March, 1948.

RESULTS—It is impossible to give any definite results as the experiment at Penistone was not scientifically carried out. There were no controls and no day to day records. Heights and weights were recorded over a period of eight weeks. There were three sets of children in the experiment; (1) Selections from an “A” form—most intelligent class; (2) Selections from a “B” form—less intelligent class; (3) Selections from a “C” form—low standard (comparatively). Of these the “A” form children showed an average increase of $\frac{1}{2}$ -in. in height and 2-lbs. in weight—“B” form $\frac{1}{4}$ -in. in height and $1\frac{1}{4}$ -lbs. in weight—while “C” showed comparatively little change in height or weight. I feel inclined to minimise the importance of the “Results”, as the gains were too small over too short a period, and in too small a series to be significant.

REACTION OF CHILDREN TO PROCEDURE—The children were very enthusiastic in the experiment. They took it as a sort of game, and the elder ones as a necessary adjunct to their daily diet. Their Biology studies had been so co-related that they realised this taking of capsules of vitamin A and D was a means of acquiring these necessary food factors. They have had it explained to them that these capsules were as important to them as their milk and dinner which they obtained at school. There never was at any time any feeling that they were being given capsules as a “pill”, but that they were the alternative to a spoonful of cod liver oil which they all abhorred and were glad to miss, and were on a par with the accustomed extra milk ration.

REACTION OF PARENTS—The fullest co-operation was received from the parents who took the responsibility of seeing that the children had their capsules at the weekend and holiday periods. Some parents volunteered the information that their respective children showed improvement in health—in two cases persistent “skin conditions” had cleared up completely.

DISCUSSION

Qn. 1. The 30 calories yielded by the 3 grammes of fat in a daily teaspoonful of cod liver oil may for practical purposes be disregarded in balancing the diet. (Margarine would have been an easier form to supply). Hence the dietetic value of cod liver oil may be regarded purely as that of its vitamins. The corollary of this is that other things being equal, vitamin concentrates are equally as acceptable as cod liver oil.

Qn. 2. This principle has been settled for us by the Ministry of Food free issue of cod liver oil on ration books to all “under-fives,” and the Ministry of Education free issue on requisition to any school children. Paediatric authorities concur:—e.g. Mitchell-Nelson (1945), p. 77, 78: “Since vitamin D is inadequately supplied in the natural diet, all children should receive supplements of cod liver oil or substances having vitamin D activity sufficient to supply from 400-800 i.u. daily throughout childhood and adolescence.”

“In the diets of children vitamin A and its precursors are supplied in liberal quantities so that deficiency symptoms from their lack seldom develop. The usual diet of children appears to supply sufficient vitamin A and carotene to meet their requirements.” The same text-book gives the daily requirements of senior school ages, 13—15, as:—vitamin A—4500 i.u., vitamin D 400-800 i.u. It is possible that under the restrictions of British war-time rationing, the opinion quoted above for vitamin A might need revision, but the value of cod liver oil as a supplement is founded securely on its vitamin D content. The practice of giving cod liver oil or its equivalent to ALL school children during periods of nation-wide rationing may, therefore, be endorsed; the distribution should not be limited to cases medically selected as showing gross signs of deficiency disease.

Qn. 3. On the above decision, cod liver oil and vitamin D and A concentrates are equally to be regarded as food supplements for school children, not as medicines. The fact that the concentrates are conveyed in a small capsule or tablet does not compromise this view. Bulk and calories are no criteria for essential food factors such as vitamins.

Qn. 4. The bottle-and-spoon method of administering cod liver oil is open to three serious objections:—

- (a) Tedium, messy technique and risk of contamination.
- (b) The unpleasant taste leads many children to dodge the daily dose, thus defeating the purpose of the issue.
- (c) Dosage at best is erratic. How many children lick the last hundred vitamin units off their spoon?

These defects in the method must strain the loyalty of school staff to the scheme. It seems doubtful whether any schools would operate this method satisfactorily, except for temporary spurts under exceptional stimulation.

Qn. 5. The capsules used throughout the recent Penistone trial were Halibut Liver Oil capsules. These are small, apparently not more than 5 minims. Each contains a dosage of:

Vitamin D—450 i.u. (Compare M.O.F. oil, 700-800 i.u. per teaspoonful).

Vitamin A—4500 i.u. (Compare M.O.F. oil, 3500-4000 i.u. per teaspoonful).

One capsule is thus a full daily maintenance dose of both vitamins for a senior school child, irrespective of what may have been taken in the diet.

A single small daily capsule of such a formula as this would be an extremely easy and elegant mode of supplying the required vitamins to all school children, with the advantage that every unit would be absorbed without waste. Any extra expense as compared with cod liver oil by spoon would probably be off-set by the saving of unwasted vitamins, and of time of school staff and teaching hours. This could be checked by simple costing.

As vitamin D is stored by the liver for considerable periods there is no necessity to provide week-end or holiday doses; it may safely be presumed that throughout the summer long vacation direct skin irradiation will afford all the self-generated vitamin D supplement needed for the period. (Whether any propaganda value attaches to carrying capsules home from school is not a paediatric problem). Not more than ONE capsule a day of the brand used should be given to any school child.

Qn. 6. Granted that a daily capsule in the classroom at school may be the most efficient mode of universal administration of vitamins D and A, is there any undue risk of turning the citizens of the future into pharmaceutical faddists?

A pill is no worse than a potion, and a capsule may be held as innocent as a teaspoon. The principle of hypodermic needles has been firmly fixed upon the public by our inoculation campaign, yet we do not apprehend racial degeneration in the form of hypodermic addiction. School biology and hygiene teaching can as easily inculcate the value of a concentrate as of a raw oil—there is no virtue in keeping so far “back to nature” in the matter of vitamins, and a capsule of vitamins can be made to seem as normal as the extra salt parade enjoined for troops in the tropics.

Qn. 7. In the last analysis, the very necessity for this discussion reveals the pitiful shortcoming of our present nutritional situation. Aside from the inevitable limitations of post-war rationing of food imports, why do we have to insist on vitamin supplements? It is abhorrent that we cannot trust the mothers of the nation to provide their children an adequately balanced diet in respect of all essential substances. A new long-range educational campaign is the only self-respecting solution.

CONCLUSION

As stated above, one cannot deduce anything from the results, nor can one satisfactorily comment on the increased height and weight in the more intelligent group. But one can say that this system of administering a supplementary food is the most suitable. There does not appear to be any indication of the “pill swallowing” complex being engendered in the children at Penistone. They are educated in the reasons for the capsule taking. I do not think the teaching staff would submit to the old spoon and bottle method unless some real incentive was behind the procedure. In the '30s when the depression produced the under-par child, the teaching staff considered it was a conscience matter to do what they could to off-set the undernourishment as evidenced in the children. The Head Master doubted very much whether the incentive at present was strong enough, and he agreed it would be extremely difficult to get staff and pupils to undertake the old method of distribution of vitamin A and D which proved very uphill work. In hot summer weather he considered it would be quite impracticable.

It is our considered opinion that vitamin A and D is a supplementary food and should be prescribed as such to school children as and when necessary. We are further of the opinion that the method of choice of administration is by small capsule, each capsule containing 4500 I.U. vitamin A and 450 I.U. vitamin D, e.g., halibut liver oil capsules. We do not consider that the taking of these capsules will create in the minds of the children the impression than an era of “pill taking” is about to emerge—particularly if the school curriculum provides some opportunity for education in physiology and hygiene of the children concerned, as to the reasons for the procedure.”

The work of a Children's Specialist in The School Health and Child Welfare Services

Dr. C. C. Harvey, Child Health Officer, submits the following notes on his work. It will be appreciated that these cover the whole range of the child population and are not concerned solely with school children:—

Administrative Report

The Paediatric Service of the County Council has passed its second year in an atmosphere of protracted uncertainty regarding policy, against a background shading from procrastination to retrenchment. Clarification of the position of our service in relation to the National Health Service would at once permit healthy development. Measurable dividends have already been yielded in the disposal of arrears of problems of physical handicap; and the everyday case-consultations of the County Health Divisions have been dealt with on an increasing scale.

SECRETARIAL STAFFING—Most regrettable, though, has been the fact that secretarial staffing has not been afforded to keep pace with the development of the paediatric service, so that important preventive projects, planned for 1949, had to be shelved. This second year has been professionally humiliating in its failure to reach the reasonable targets set for preventive achievement in my first annual report. The scope of my post had been laid down in the Memorandum of Conditions of Appointment, published in 1947. All that was to have been distinctive, however, in this new type of Public Health Paediatrics has been jeopardised and halted through inadequacy of staffing of the service. These matters are not a clinician's hobby—to the West Riding County Council they are of life-saving, time-saving, education-saving, and finance-saving value. It is essential that time should be set apart for these positive developments; and such time can only be found by efficient streamlining of the whole of the Paediatrician's work, so that none of his time should be spent in secretarial activity which could be efficiently delegated.

I am not concerned merely for the dictating and typing of clinical case-reports, important though they be as one aspect of our service (see below: Relations with Family Doctors). My aim is to develop a Consultant/Secretarial team with consequent considerably increased capacity for turnover of case-consultations (say 25%), and greatly enhanced striking-power in clinical preventive research. Such research is not an optional academic hobby, and it is not an administrative undertaking, but is of the essence of consultant advisory service for the future welfare of our child population. It includes, for example, the detailed, repeated, painstaking study and classification of our various series of handicapping disabilities; for such study alone can give us the clues to rehabilitating these children and to advising on preventive policy for the future. Examples of work awaiting development include:

1. **ASTHMATIC SURVEY:** Relative importance of heredity, allergy, overcrowding, family morale and psych-somatic aspects; response to treatment by remedial exercises and drugs.
2. **EPILEPTIC SURVEY:** Complementary on the clinical level to the administrative survey made at County Hall, attacking the wastage of educational time due to haphazard treatment failing to control fits.
3. **CEREBRAL PALSY:** Especially mental assessment in infancy, and early diagnosis with view to early treatment.
4. **HEART DISORDERS:** The clinical appendix to this report justifies the plan for a widening study of both rheumatic and congenital heart disorders.
5. **PARENT GUIDANCE:** Individual cases are time-consuming and there is no short cut to success.
6. **PAEDIATRIC CLINIC CASE-MATERIAL:** Classifying and interpreting the wealth of data now accumulating in each Division and Hospital, including the medical causes of school absenteeism.
7. **RECORDS AND DATA OF INFANT AND SCHOOL HEALTH:** e.g., the practical value of Professor Illingworth's recent papers on birth-weight in relation to later physique.
8. **NORMAL STAGES OF INFANT DEVELOPMENT:** The work of Arnold Gesell is fundamentally important for early estimation before the age at which Terman-Merrill intelligence testing can be applied.
9. **BREAST FEEDING:** One of the most important single lines of attack on the infant mortality problem, immediately open to development (ref. my last Annual Report).
10. **PREMATURITY SURVEY:** More of my time needs to be devoted to the supervision of urgent premature cases and to preventive measures.
11. **GASTRO-ENTERITIS OF INFANCY:** Leading (as at Newcastle) to socio-medical investigation of whole households for infection.
12. **B.C.G. VACCINATION** will require time this year and in future, in liaison with Consulting Chest Physicians.
13. Development of fruitful direct links with Departments at Leeds General Infirmary, as already established at Sheffield.

Examples of serious wastage of my time through the existing defective arrangements could be multiplied many times. I am not so much concerned over these delays, confusion to family doctors, arrears of clearance of cases and restriction of output, as regarding the failure to make

positive progress and development in our child health service. This failure is costing the lives of babies now being born in our County. For instance, a rigorous statistical proof will not be needed for the proposition that babies are now dying whose lives would have been saved if our campaign to promote breast-feeding could have been developed one year ago, as proposed in my last Annual Report (ref. Ministry of Health Report No. 94, 1949, p. 43-4). Looking forward, a well integrated secretarial establishment would be an invaluable safeguard of the inter-related County and Hospital aspects of our paediatric work. This safeguard can best be set up now before the shape of my hospital services becomes crystallised beyond re-modelling.

Finally, notwithstanding all the above representations, I acknowledge warmly the cordial, efficient and prompt help afforded to me by all the Divisional Health Offices, and again especially by Dr. Penman's staff.

RELATIONS WITH COUNTY PUBLIC HEALTH DIVISIONS. There has been consolidation of my monthly Paediatric Clinics in the nine Divisions of southern Yorkshire, and some extension northwards, where an increasing number of Divisions are referring children to the Out-Patients Department at Wakefield General Hospital. In addition two special Paediatric Clinics for cardiac problem cases in Division 20 have been held at Dr. Ward's invitation at Golcar. Liaison is planned with the Cardiac investigation now established at Harrogate. In three Divisions the Divisional Medical Officer regularly shares in the monthly Paediatric Clinic. In four other Divisions the Assistant County Medical Officers regularly share in the Clinic. Assistant County Medical Officers from two northern Divisions have repeatedly attended the Out-patient sessions at Wakefield General Hospital with their cases. Such direct consultations are refreshing and invaluable to both parties; an extension of the practice in other Divisions would be welcome, when timetables permit. The Assistant County Medical Officers from three Divisions take advantage regularly of the post-graduate facilities at Sheffield Children's Hospital by Professor Illingworth's invitation. I meet the Divisional Medical Officers in their offices during my monthly touring, for general discussion and also regarding particular cases. Some of these problems I then take direct for special investigation to consult Professor Illingworth at Sheffield Children's Hospital. Each month I take selected cardiac cases for investigation by Professor Wayne in the combined clinical, x-ray and electro-cardiographic session at Sheffield Royal Infirmary. To these consultants our thanks are due.

By the kindness of Dr. M. C. Taylor, Acting School Medical Officer of the City of Sheffield, we have had the advantage of expert assessment of certain problems involving hearing defect, including a day's observation by Miss Elliott at the Maud Maxfield School for the Deaf.

RELATIONS WITH FAMILY DOCTORS. During this second year I have aimed increasingly to improve the quality of correspondence with doctors over their cases, writing fuller and more reasoned reports and recommendations, signing all letters personally and following these up where appropriate by telephone discussions. Dr. Leslie Cole recently stressed (*Brit. Med. J.*, 1950, i, 662) the value of personal contacts between Consultants and General Practitioners. His remarks about hospitals apply equally to our type of work:—

"If a very high standard of work can be attained and contacts be maintained with all doctors in the area, the whole medical tone will automatically rise. Of these contacts, perhaps the letters written by practitioners to consultants, and vice versa, are the most important. The doctor can so often provide the missing link essential for diagnosis. The work done in the hospital is often largely wasted if a clear report is not sent promptly by the consultant or his representative when the patient is discharged, or after he has been seen in the out-patient department. If such letters are of high standard their educational value is enormous. It follows that the staff secretarial organisation must be highly efficient, and it should be deliberately developed to play its part in teaching."

All this takes time as well as staff. Its rewards will be found in a closeness of co-operation that carries its own preventive values, as problems come to be shared at an earlier and more curable stage. Home consultations at the invitation of family doctors have not been numerous, but have afforded insight into the difficulties of general practice as well as of life in industrial areas. Family doctors are writing more and more detailed letters introducing their patients, and in some cases are giving valuable socio-psychological data.

WAKEFIELD GENERAL HOSPITAL. At the close of 1949 we lost the advantage of Dr. C. W. Vining's invaluable fortnightly attendance as Senior Consultant. The Out-Patients serve a still wider County area than last year. Dr. Rosenthal's encouragement and co-operation has been much appreciated, regarding both out-patients and wards.

MONTAGU HOSPITAL, MEXBOROUGH. The Montagu Hospital is the centre of a very populous area, full of urgent clinical work and preventive problems which interlock inextricably. The out-patients session badly needs increasing to once weekly instead of twice monthly, to enable us to do justice to the volume and acuteness of the work, especially among young babies. The suggested appointment of a Paediatric Registrar would at once make possible a rapid advance in the Paediatric Service in the area, both in the Hospital and outside.

DONCASTER ROYAL INFIRMARY. There have been fruitful exchanges of reports with Dr. L. A. Hawkins, and many of our children have attended for treatment in the various hospital departments. The monthly clinical staff meetings continue to be most stimulating.

MATERNITY HOMES. Calls to see babies in former County Maternity Homes have ceased during the year. I am not clear whether this is due to protracted uncertainty regarding my Hospital status in the areas concerned.

SHEFFIELD CHILDREN'S HOSPITAL. Professor Illingworth's insistent emphasis in teaching upon the normal, upon the everyday and preventable disorders, and upon behaviour problems of infancy and school life, implies a strong sympathy with the sort of work in which we are engaged. He and his colleagues appreciate the wealth of clinical problems which the County affords for study. This association continued to be the most valuable component of my appointment, for general guidance, for the ultimate advanced study of our more baffling cases, and for the post-graduate teaching which some of our Assistant County Medical Officers are enjoying. During the year I had the privilege of contributing a minor share, based partially on data from our County school-children, to Professor Illingworth's research on the "Relation of Birth Weight to Physical Development of Childhood" (Lancet, 1949, ii, 598).

INGLEBOROUGH HALL SCHOOL. This residential school was opened during the year and I hope to continue visiting approximately once a term. The initial results have been gratifying. The provisional policy seems to be to admit only children who are sufficiently able-bodied to benefit fully from the magnificent surroundings of the school. This leaves still untouched the more advanced handicaps, which require much more individual care, with less capacity for physical activity.

My indebtedness continues to Dr. Lane at the Medical Research Council Laboratory at Wakefield, and to the Consultant Chest Physicians, as last year, for the hospitality of their clinic premises and for their generous help with x-rays of our children, the congenital heart series in particular.

Clinical Paediatric Report

The first section attempts to synthesize the recurring clinical impressions of everyday work, with illustrative case notes. Then follows a section referring to some special problems not already covered, and the report closes with a section in which some preventive considerations are raised.

(A) PRIDE OF PARENTCRAFT.

It is unaccountable that the personnel of Britain's greatest industry, the reproductive industry, should remain so inadequately briefed upon their task. There are millions of parents, homes and prams devoting their full energy to record man-power output. There are thousands of doctors, nurses and clinics at work; scores of "productivity teams" and conferences publish reports. And yet every paediatrician's time is largely occupied in correcting mistakes of management, refuting ancient fables, and unravelling domestic tensions. How grateful some parents are for one morsel of commonplace self-evident advice, for lack of which their home life has become a nightmare of anxiety over the baby. How many, without such advice, are discouraged from facing further reproductive adventure, the bright glow of pride in their achievement having all faded. The first baby's first year ought to proceed physiologically, smoothly, satisfying both parents with its emotional rewards, so that they will be positively disposed towards adding to their family in due course. Far from being an armchair sentiment, this bears acutely on such mundane problems as failure of lactation, discord with "in-laws", and child behaviour.

Some mishaps and diseases of babyhood are admittedly unavoidable, yet our clinical sessions are half-filled with preventable breakdowns, all the year through. We ourselves are partly to blame for our past conflicting professional dogmatism. Our task in infant welfare will not be fulfilled until parents generally are briefed to the minor pitfalls which cause so much misery and discouragement. Some of these are illustrated below:—

1. **RIGID FOUR-HOURLY FEEDING OF YOUNG BABIES**, whose size, energies and requirements are so varied that only individual timing of feeds can be satisfactory. Parents and nurses should reckon for the new-born baby demanding to be fed many times on the first few days. The very frequency of his demands is a needed stimulus to lactation. The practice still enforced by some midwives of putting the baby to one breast only, alternately at each feed, is thus doubly disastrous. Misgivings are still expressed that the baby will take advantage and secure "spoiling" if allowed a self-demand schedule. In fact, if fed adequately each time on demand, a baby shakes down sensibly in a very few weeks to a routine which allows mother leisure, without the stormy conflicts of hunger imposed by rule of the clock. "Self-demand" is in the long run less exhausting to mother, nurse, father, grandparents and child.

2. **UNJUSTIFIABLE EARLY CESSATION OF BREAST FEEDING** because baby cries or "has wind", on the plea that the mother's milk does not suit him or has "turned to water." The remedy often lies in relaxing arbitrary time schedule of feeding, with temporary complement feeds during the second fortnight of life, usually the lean period of lactation. The long-range prevention of such difficulties lies in the general adoption in ante-natal practice of daily manual expression of colostrum and, if necessary, the wearing of plastic "Woolwich" Nipple Shields to correct flat nipples, in the later months of pregnancy.

3. **OVERCLOTHED BABIES**, pathetic, restless and exhausted, are commonly brought up in many layers of woollies, even in summer, the parents distracted over their refusal of diet. Too many blankets in cot or pram have the same effect.

4. **VOMITING BABIES** are often referred in alarm, despite their appearance of vigorous health, their normal weight-gain and the record of normal stools. These reassuring signs frequently indicate an innocent trick of "possetting" which can be disregarded after checking over the details of feeding technique.

5. **RESPIRATORY INFECTION** in young babies, as in older children, is often overlooked as the cause of going off their feeds, due to the embarrassment of a choked nasal airway. When this oversight leads to changing from breast-feeding to a vain succession of different artificial diets, it is particularly regrettable.

6. **DIVIDED AUTHORITY** is the common result of overcrowding, with a grandmother undermining the young mother's self-reliance and discipline. The baby suffers in various ways, through confusion of routine. For future study, the possibility remains that some of these cases of mismanagement may rather be an expression of the incompetence and dependence of a young mother, who takes refuge in the older woman.

7. **THE FOOD-FORCING SITUATION** crops up every week with fascinating regularity and conformity to type, among toddlers and infant-school children. Parents in many cases have some undisclosed fear, often of tuberculosis. Re-briefing upon the wide range of normal child appetites, with proof of normal weight and height for age, commonly suffices to cut the vicious circle.

Attention may here be drawn to Professor Illingworth's work, showing that children who were premature in size at birth will on average be lightweight and small, though healthy, up to puberty. Ignorance of this principle has caused much sorrow to parents, as they have cast fearful glances across the garden wall upon their neighbour's bonny offspring. In other cases, lightweight in a child is a replica of a parent's physique.

8. **BOWEL FORCING** is equally pernicious at all ages. Despondency may shadow the household for months if parents are left unaware that it may be normal for their young baby's bowels to move efficiently once every four days. Recourse to proprietary purges often upsets the natural rhythm. At a later age, conflicts of habit training cause distress; and stubborn examples have been encountered this year, for example:—

- (a) Tough schoolboy aged 8, with bowel incontinence (actually "overflow soiling" due to solid constipation), whose foolish mother set an older sister, aged 13, as sentinel upon his lavatory sessions. No developed active interests in life, spends four afternoons a week at cinema throughout the summer holidays.
- (b) Boy aged 6, with enuresis, and bowel "accidents" by day, victim of "smotherlove" by invalid mother who appears at school gate every day at morning break and again at dinnertime to remind him to go to stool.

9. **RESPIRATORY INFECTIONS** should, in the infant school years, be expected on an increased scale. If the child be fortunate enough to get into a nursery class before 5, the onset will be so much earlier; but I think the advantages are worth the risk. Though we cannot rest content with this situation, immunologically, yet we could prevent much needless school non-attendance and worry among uninformed parents (e.g., fearing tuberculosis) during the snivelling period, the temporarily tonsilliferous age of man. The doctors' problem is to sort out the symptoms and signs of the minority who require special treatment. Allergy to domestic dust or pollen needs to be recognised as a non-infective condition, often with seasonal exacerbations in nose and sometimes in chest (summer asthma). Asthma in childhood may only appear during infective colds, or may, during infections, be aggravated so that customary remedies are temporarily ineffective. Remedial breathing exercises have recently given great satisfaction. Nasal sinusitis persists, in between acute colds, and commonly maintains a moist cough. It shares with adenoid obstruction the blame for choked nasal airway, but it is the adenoids that lead to varying deafness and ear-discharge, which should be our signal for prompt reference to the Aural Surgeon. The type of case which alarms parents most often seems, in fact, to be a trivial tracheitis, with a paroxysmal, dry, noisy, nocturnal cough, which wakes grown-ups night after night for weeks. Paroxysms may provoke transient mild wheezing, which can lead to a wrong suspicion of asthma. Reassurance and a Codeine Linctus are called for.

10. **TONSILS** need judging in the perspective of their natural history, that if they can be left alone, respiratory infections decrease in a few years. Their size and appearance (especially at a single inspection during a cold) are no guide; but frequently recurring sore throats would justify reference to the Surgeon. If a general amnesty could be declared upon school tonsils, we should give our surgical colleagues opportunity to deal promptly with the much more serious adenoid and antrum cases, which can ill afford to be delayed on waiting lists.

11. **TEMPERAMENTAL VARIATIONS** between the children in a family can puzzle unwise parents to an astonishing degree, and cause serious mishandling. A "Behaviour disorder" was referred by a harassed elderly mother in her youngest child, a charming splendidly built girl of ten. The brothers had grown up many years ago sedate creatures, whereas Jane will not be a little lady, and "ought to have been a boy." Her bicycle has been sold because her father objected to her riding in rural traffic. She has never been allowed to go away on her own to camp.

One last need for briefing of parents concerns the normal approach to sex in adolescence. Several mothers this year have betrayed a morbid revulsion from the physiology of menstruation, calculated to warp their daughter's whole attitude at the outset. ("It's the time of life **THREATENING** her, doctor," to explain boredom in a thirteen-year old).

This essay on "Briefing" would be incomplete without the recommendation of reliable reading on the subject. Happily, an ideal book is available at an ideal price, for parents and equally for nurses and doctors: "The Pocket Book of Baby and Child Care" by Benjamin Spock (2/6 "Pocket Book Series").

(B) SOME SPECIAL PROBLEMS.

EMOTIONAL MALADJUSTMENT. Disorders in this group are more often in the parents than the child. M. Kaplan has recently pointed out (*American Journal, Diseases in Children*, 79, 795, May, 1950) that the child is a delicate barometer reflecting the state of feeling within the family (the disturbed child is a symptom of disturbed family relationships). From this it follows that Paediatrics is a practice involving the whole family, not the disordered child alone. Our offer of "parent guidance" may not be welcome, implying as it does a criticism of family policy. We do not always have the advantage of meeting both parents; and there are limits to our powers of interference, in a democracy where the citizen has the right to be wrong. Gratifying responses, however, are frequent in the simpler cases.

Habit spasms are again commoner than chorea, for which they are commonly misdiagnosed. Occasionally this is serious, as in a boy who had chorea (probably) at 9, which after some months of family worry left him with complex habit spasms, which lost him a further $2\frac{1}{2}$ years of school time in vain. Most of such youngsters appear to have one forceful dominant parent, whose driving ambition and interference have disrupted their serenity. The homely expression "All Natterified" puts this concept in a nutshell. A special group with habit spasms is found in the Secondary Modern Schools, educationally dim worried children who react in this form to the unequal strain of academic competition.

Illegitimate children are commonly reared by the grandmother, as the mother either goes out to work or has married and gone elsewhere. Time after time I have found these elderly women reduced to jittering desperation by the strain of caring for a growing spoilt "only child": their old shoulders have not the elasticity to carry the load, especially as it is a proxy responsibility, with a concealed sense of shame.

Another adverse situation concerns the unhappy child adopted by an elderly woman who is beyond the ability to play with the growing youngster. In one such case, aged 5, the father cannot understand why the boy will not obey, and fears disease in him. The School Medical Officer, Consultant Psychologist, and the Head Teacher all agree that he is a bright intelligent impulsive child.

An example of mishandling was a pathetic undersized eldest girl aged 12, not bright at school, handicapped by squint and lisp, who was left night after night in sole charge of five younger children while the parents spent social evenings elsewhere. Father publicly resented her failure in scholarship examinations and denied her a bicycle. Her unimaginative mother had never allowed her to share the joys of cookery at home. She had developed a habit of running away from home when afraid of punishment. Response after her first interview was encouraging.

In several of our more complex emotional and psychological problems we have again valued the help of Dr. M. M. MacTaggart, not only for precision of diagnosis, but also for her painstaking therapeutic counsel to parents and children.

BEDWETTING is one of our foremost problems numerically. We need to learn how to select children for urological investigation, so as not to overload the surgeons interested in organic causes. Simple faults of management are responsible for some other cases. A few have responded promptly to Amphetamine, designed to stir up the subconscious sentinel of bladder-awareness. Correction of mouth-breathing may, possibly, help. Intelligent use of an alarm clock may help to re-establish some older failures. Other delayed "successes" must be credited to time and nature rather than to our prescribing.

HEART DISORDERS. Congenital malformations are dealt with in a lengthy clinical appendix covering two years' experience, which indicates the magnitude and fascination of this practical study. In Rheumatic disease, the syndrome "Incompetence—but not Mitral" has happily been little evident this year, though one case was encountered of prolonged coddling of a ten year old boy with minimal mitral scarring. The need is pressing for a hospital school within our territory for adequate initial prolonged treatment of rheumatic fever, and for severely handicapped hearts.

POLIOMYELITIS, notwithstanding its headline alarms and protracted sequelae, is yet a minor disease compared with tuberculosis, and the killing diseases of infancy. One instructive case occurred in devastating paraplegic form in a 6 year old girl, ten days after an acute appendix operation.

(C) SOME GENERAL PREVENTIVE CONSIDERATIONS.

B.C.G. VACCINATIONS against tuberculosis, introduced during the year, will probably be a notable landmark in the campaign against this disease, especially as earlier measures have reduced the proportion of children whose tuberculin reaction is positive. The value of B.C.G. in diminishing the risk from exposure to tuberculous contact is associated with its ability to convert negative to positive tuberculin reactions. When this conversion is caused in young children by virulent tubercle bacilli, the risks of tuberculous illness and death are considerable. At present in this country B.C.G.

work is still at the "pilot survey" and tentative stage, and must be carried out under special safeguards against discrediting the method. Our plans should, however, now be laid for widespread use of this protection as soon as relaxation of restrictions may allow. For such a nation-wide immunisation campaign, it will be imperative to know the "Tuberculin Status" of our population at all ages. It will also be of great value in individual cases of illness to know from the records whether yet tuberculin positive, thus sometimes saving the time needed for testing afresh. I recommend that it would not be too much to set our target at recording the tuberculin jelly test on all children at the ages of 1, 5, and 11 years (or second school medical inspection). The jelly could be applied by the nurse four days before the school medical officer's inspection, or in the case of infants, one week before inspection. Such a general survey will yield additional rewards: unexplained positives will occasionally discover an infective adult, or the use of a faulty milk supply. The infant and school record cards should have spaces designated, not only for birth weight but also for tuberculin test results at several ages.

WHOOPING COUGH VACCINATION awaits perfection, but the cases of bronchiectasis dating back to pertussis in babyhood indicate that such vaccination must be done before six months of age, for full value. Some recent convalescent pertussis cases have shown widespread patchy lung collapse on X-ray films: ideally such study would be desirable in every case within two months of illness, but at present our technical resources might limit us to X-ray of cases with residual clinical signs or following serious attacks.

ULTRA VIOLET RAY CLINICS. I have been impressed by the amount of time expended by parents and children in attending U.V.R. courses, often at a considerable distance from home. The main value lies perhaps in keeping neglected children under close observation for nutrition and cleanliness, with opportunity for instructing parents.

PHYSICAL CULTURE UNDER ACADEMIC STRESS. In more than one Grammar School, if my information is reliable, the School Certificate and Higher Certificate Curricula are allowed to crowd out compulsory games and exercise, at the peak periods of study when the un-athletic can least afford to go stale. Keen athletes will take care of themselves; but I suggest that the general relaxation of emphasis on physical fitness is false economy for examinations and a bad precedent for the future. Further, parents should not devolve upon the school the responsibility for keeping their children fit for study at these seasons of stress.

C. C. H.

Interim Report by Dr. C. C. Harvey, Child Health Officer, on Congenital Heart Lesions in Children

Detailed knowledge of the incidence of congenital malformations of the heart in our population has hitherto been lacking. Since the presenting types vary at different ages, changing pictures are seen in maternity practice, infant welfare work, hospital post-mortem rooms, and a school health service. Thus a long range inclusive survey is needed to afford perspective; and this would call for the keen interest of all family doctors as well as hospital staff and the medical officers holding Infant Welfare and School Clinics. The newly-afforded surgical prospects for some cyanosed cases, and the value of precise guidance to all cases, will amply reward such interest. A comprehensive study of the problem will involve discovery, registration, identification, guidance (and in few cases surgical treatment), and follow-up of cases into adult life.

A beginning was made just two years ago in the southern half of the West Riding County, with the keen co-operation of all the full-time County medical staff, and a gradually growing interest among family doctors, many of whom hold welfare clinics.

So far 109 children have been referred, either to County Paediatric Clinics or to hospital out-patients:—

91 school children.

18 under school age (the lower ratio suggesting that liaison is not yet so effective with their immediate medical advisers, before they enter the scope of the school health service).

For what it may be worth, girls predominate over boys in both these small groups, in the ratio of 5 to 3 (57:34 and 11:7 respectively).

RATE OF COMPILATION. The graph of additions to the register still rises, without suggesting that a limit is being reached after 24 months. Few children aged 8 and 9 have yet been referred—probably many such are awaiting detection at their second school medical inspection about the age of 10.

The graph for rheumatic hearts shows only 54 cases referred through the same channels in the two years. This ratio of 2:1 cannot be taken as final; but I believe it will remain true that recognisable congenital heart lesions outnumber recognisable rheumatic heart lesions to an appreciable degree in this area among school children. This contrasts with surveys elsewhere:

San Francisco—45% Congenital to 55% Rheumatic.

Iowa—42% Congenital to 58% Rheumatic (Robinson et al. J. Pediat, July, 1946).

The third, parallel, curve shows 48 cases in 2 years labelled clinically as "Innocent Murmurs." These have not yet been studied in detail, and will doubtless lose a number to the Congenital series, and a very few to the Rheumatic. To their own doctors these children have often been as much worry as the true organic lesions.

AGE AT DISCOVERY	...	...	...	...	0	1	2	3	4	5	6	7	8	9	10	11	12	13
Found by Family Dr.	...	...	...	...	33	7	5	2	3	7	3	0	0	1	0	0	0	0
Found at Clinic	...	...	...	...	6	0	1	3	5	12	3	5	2	3	1	1	2	2
Found incidentally	...	...	...	...	25	4	4	4	8	18	5	5	2	4	1	1	2	2
Heart Symptoms	...	...	...	...	14	3	2	1	0	1	1	0	0	0	0	0	0	0

Only 22 (out of 107) were brought to light by true cardiac symptoms, or signs such as cyanosis. 85 were discovered incidentally when examined, e.g. for bronchitis, threadworms, after falling into the canal, before going to holiday camp, or at school. Over half (61) were found by the family doctor, the rest (46) at infant clinic or at school, where 33 were located at routine inspection. Almost half were not discovered till school age—50 against 57. 10 were detected at birth. In 4 the actual heart signs were first observed by the mother—audible murmur in three cases, and one rapid heaving heart beat.

TYPES OF CASE. These are provisional, as few have yet been fully investigated. But representative cases from each group have been examined by Professor Illingworth, or at Sheffield Royal Infirmary by Professor Wayne; and to them I am indebted for the landmarks of diagnosis.

The classification is over-simplified for tabulation:

CYANOSSED. (21 cases)

12 Fallot (4 having been investigated and explored surgically elsewhere, with 2 successful Blalock anastomoses).

3 Eisenmenger (2 probable, 1 definite with Rt. Pulmonary Atresia).

1 Pulmonary Stenosis (with Mitral Stenosis and ? Septal Defect).

1 Uncertain—? Tricuspid Atresia.

1 Coarctation of Aorta (with Auricular Septal Defect and ? Ductus).

2 Gross Defects with early death aged 3 and 39 days.

1 Lutembacher, with death at 7 months.

WITHOUT CYANOSIS. (88 cases)

35 Ventricular Septal Defects (4 gross lesions).

14 "Basal Systolic" signs: unclassified as yet.

13 Ductus Arteriosus (10 with full machinery murmur).

4 Lutembacher (with one, cyanosed, above, who died).

5 Auricular Septal Defect, thus far identified.

4 Pulmonary Stenosis—isolated.

1 Auriculo—Ventricular Septal Defect (Mongol).

4 Aortic Stenosis.

1 Dextrocardia—simple, with Situs Inversus.

7 Diagnosis deferred on grounds of age (under 5).

To a clinician in the field, the group with basal systolic signs is the most baffling; and it might repay study for possible differentiating clues, such as radiation of murmur to the neck. With some of these cases, there will be the ethical question to face; are we in this instance justified, for diagnosis or prognosis, in submitting the child to elaborate in-patient investigations, with the risk of a cardiac neurosis?

Case-study from babyhood onwards will be more valuable than study commencing only at school age.

PRE-NATAL FACTORS, possibly causal, were noted in 5 cases:

Rubella at 2nd month Ductus (case 83)

Haemorrhage 3rd month Ventricular Septal Defect (15).

"Periods" up to 6th month Fallot (case 88).

Menopausal amenorrhoea, aged 42 "Basal Systolic" (case 112).

Shingles ? mid-pregnancy Gross Septal Defect (case 28).

THERE WERE, BESIDES, 2 MONGOLS:

Ductus—girl age 10, observed to close at 10½ years (case 17).

Auriculo-Ventricular Septal Defect—girl aged 3 (case 50).

EDUCATIONAL SUBNORMALITY was noted in 4 other cases:

Auricular Septal Defect (case 22).

Gross Septal Defects, probably ventricular (cases 28, 80).

Fallot (case 81)—caution, being an institutional orphan.

PHYSIQUE WAS SUB-STANDARD in nearly half the cases, of all types:

42 out of 94 children (excluding infants) were more than 10% below average weight for age on Holt's standards. This was not due to prevalent premature birth: only 11 out of 83 (recorded) had weighed $5\frac{1}{2}$ lb. or less at birth; while 19 out of 83 had weighed $8\frac{1}{2}$ lb. or more. The data for height are thus far inadequate.

RESTRICTION OF GAMES AND EXERCISE. 22 out of 78, i.e. over one quarter of the un-cyanosed school children, had suffered unnecessary restriction of interesting activity, even to Grammar School years. In two cases, legal enforcement of removal to Physically Handicapped Schools was under consideration. These restrictions had led variously to psychogenic tiredness and breathless attacks (with proved normal exercise tolerance), tantrums, enuresis, exotic 'extravagances' in fashion (High School Sixth Form), truancy ending in a remand home (boy aged 10 with ventricular septum, who had been the best swimmer of his school till forbidden sport). One simple ductus was always carried upstairs till 5, and her doctor protested stiffly against de-restricting. Another simple ductus had a boarding school career cancelled after her whole outfit had been purchased. A different case was that of a profound emotional atrophy in a girl who had been away at a residential physically handicapped school four years without coming home, from 7 to 11, during the war; she has a complex coarctation, but has gone straight into factory work on reaching 15.

All this implies no censure on the past: during the war years consultant reference was not as easy as it is now.

FINALLY, THE DUCTUS DILEMMA—Case 7, an outstandingly athletic girl, mainstay of a crack school swimming team for several years, yet with a grossly abnormal X-ray outline, illustrates the conservative viewpoint that surgical ligation should be reserved for cases presenting circulatory embarrassment or bacterial endocarditis. Almost all congenitally malformed hearts are exposed to bacterial risk: saturation with penicillin and sulphonamides is thus a valuable routine safeguard against bacterial endocarditis, whenever tooth extractions or tonsillectomy are undertaken.

PART VI

COUNTY DENTAL SERVICE

Introduction

The following is the report of the Chief Dental Officer, Mr. B. R. Townend, F.D.S., R.C.S. (Eng.) L.D.S. (L'Pool) :—

It is with some degree of melancholy that one takes up one's pen to write a report on the County Dental Service for the year 1949. In our last report we deplored the drift which had taken place from public dental service to private practice with the inevitable result that the care of children's teeth was suffering at the expense of the correction of the teeth of adults, many of which are in a sorry state as the result of years of neglect. There has been no improvement during the present year under review, in fact, the position has worsened. In December, 1948, we had 45 whole-time and 3 part-time officers on our staff. In December, 1949, these figures were reduced to 34 whole-time and 1 part-time officers.

There are indications that we may have reached the lowest level of our difficulties but we are faced with the problem that we have to attempt to do a job with a staff of 34 which requires at least twice that number to perform adequately.

It has been our policy during these difficult times to endeavour to maintain at as high a level as possible the clinical and preventive aspects and ideals of our work. We have felt that we could not afford to give up the gains we had made in the hard battle which has been fought and won to overcome the prejudices of the general public against the conservation of teeth, and the gradual breaking down of the popular idea that a dental surgeon was little more than a tooth puller whose services were required for the relief of pain and little else. We have felt that we must maintain as far as possible these hard won principles even at the expense of certain districts of the administrative area where it has been impossible to maintain any dental service at all. On the face of it, such a policy might appear to be heartless and unfair, but it should be realised that unless children's dentistry is done properly it is hardly worth doing at all. To be done properly it must be an organised campaign with adequate staff. Every child's mouth should be examined early in life and subjected to further examinations at periods not exceeding twelve months so that defects can be detected and dealt with at the earliest possible stage. In this way and in this way only can dentistry justify its claim to be a preventive health service.

There are a few gleams of light amid this depressing gloom. We have been greatly sustained and encouraged by the deep appreciation that the general public have given to our efforts. We have tried to deal as quickly as possible with all cases of toothache and it is an indication of the breakdown in general dental service that many of these children have been taken from one dentist to another in vain efforts to obtain relief. This relief work is unfortunately growing in volume. It will continue to grow in areas where no routine dental service is available and it is having a deleterious effect upon the routine work. The time that the dental officer has to spend extracting aching teeth would be much better employed in conserving teeth before they have become badly diseased. It cannot be over emphasised that unless the preventive aspects of dentistry are stressed and are given the utmost degree of priority we shall remain in the undignified and impossible position of a dog chasing its own tail.

The Dental Treatment of Expectant and Nursing Mothers and Pre-School Children—The service for the treatment of Expectant and Nursing Mothers is making great forward strides as will be seen by comparing the present year's record of treatment carried out in West Riding Clinics with that of last year :—

	1948	1949
No. of cases treated	58	836
No. of general anaesthetics	74	440
No. of extractions	901	4280
No. of fillings	15	1065
No. of dentures	73	380

Apart from the great increase in the number of patients treated the change in the type of work being done is a striking feature of the comparison. It will be seen that last year every patient had an average of .26 fillings completed compared with this year's average of 1.2. The number of extractions per patient has dropped from 15.5 last year to 5.1 during the present year. These figures reflect the changing nature of the service from one of a breakdown character where only cases of desperate needs requiring desperate remedies were dealt with, to a service where increasing consideration is being given to the preservation of the teeth. Although this change is encouraging it should not engender in our minds any degree of complacency. We have a long way to go before we come within reach of our ideal. This should be that every

expectant and nursing mother should only require an increased vigilance during her pregnancy and nursing period in maintaining the sound dentition and good oral hygiene which she has had bestowed upon her by an adequate school dental service followed by an equally adequate general service. Until this ideal is consummated we cannot consider our dental service to be entirely satisfactory or successful. Again it must be reported that we have not yet been able to develop anything in the nature of a routine dental service for pre-school children, but a considerable number of such children are treated on reference from Divisional Medical Officers, Health Visitors, etc.

The following table gives details of the total number of expectant and nursing mothers treated during the year, including those treated by private dental practitioners:—

	County Dental Service.	Private Practitioners.	Total.
No. of cases treated	836	259	1095
No. of general anaesthetics	440	50	490
No. of extractions	4280	718	4998
No. of fillings	1065	308	1373
No. of dentures. {	Complete	26	241
	Partial	59	224

Orthodontic Scheme—The orthodontic scheme continues to make progress. It has been possible during the year to establish a new centre for this work at Castleford which has eased the congestion which was arising at the Central Clinic, Wakefield.

Orthodontics is now being carried out at the following centres:—Wakefield, Brighouse, Castleford, Harrogate and Tadcaster.

The following table indicates the steady growth of this service during the past three years:—

Attendances for Treatment.			
1947	...	...	4418
1948	...	...	7464
1949	...	...	8026

The Work of the Dental Laboratory—It may be of some interest to the County Council to know what these “back room boys” of the dental service are doing. The Laboratory has been in existence for ten years under the guidance of Mr. Ford, the Senior Technician, and has now on its staff 1 Senior Technician, 3 Mechanics and 2 Boy Apprentices. It is pleasant to record that two of the mechanics have been trained by us and after serving as dental mechanics in H.M. Forces have come back to the dental laboratory.

The work carried out by this department is very varied and of a high standard. It comprises all variety of dentures for expectant and nursing mothers and for older children who by accident or severe disease have lost teeth in the front of the mouth. A very large number of appliances for moving crooked teeth are made in connection with the orthodontic service. Crowns, inlays, bridges, in fact every branch of prosthetics is carried out in this department. In addition, a considerable amount of time, trouble and money is saved by this department being able to undertake minor repairs to equipment.

The steady growth of this department's work is shown in the following table:—

	Full Dentures	Partial Dentures	Repairs	Orthodontic Appliances	Inlays, Crowns, etc.
1946	215	96	49	343	41
1947	297	139	83	501	104
1948	334	278	69	720	138
1949	250	408	57	881	176

The Topical Application of Fluoride Solution to Teeth—During the latter part of the year a working party was set up by the Ministries of Health and Education to consider the value of the topical application of fluorine solutions as an inhibitor of dental caries and I was invited to be a member. The use of fluorine in this capacity has been extensively used in the U.S.A. and considerable claims have been made for its efficiency, claims to the effect that a reduction of 40% has been made in the incidence of caries in children whose teeth had been painted with sodium fluoride solution. It is proposed to carry out a carefully controlled experiment in this country to see if these claims can be justified. If it is found that such treatment really does inhibit dental caries it will be a valuable weapon in our armoury.

Until the working party publishes its report, which will not be for at least two years, we must bear ourselves with patience and be content with our well-tried and traditional arms of early and regular conservation of the carious tooth.

Analysis of the Work carried out during the year—The information concerning dental treatment provided for in Table V. of the Ministry of Education's returns (see page 44) gives a very limited picture of the actual work done and the following implementations and refinements to that Table (less treatment carried out in Keighley Municipal Borough) may be of interest.

EXTRACTIONS:— The total of 52,070 temporary teeth and 8,670 permanent teeth extracted does not represent as might be thought so many teeth which it has been found impossible to save. No less than 8,935 temporary teeth and 2,295 permanent teeth have been extracted with a view to making room for the other teeth or to ensure in various ways that succeeding teeth shall grow in a regular order. It will be seen from this that nearly 1 tooth in 6 is extracted with the object of preventing irregularity and ensuring the future of the dentition.

FILLINGS:— 9,212 temporary teeth were conserved by the following means:— 912 cement fillings, 1,010 amalgam fillings, 1,313 combined cement and amalgam fillings, and 6,022 treatment with silver nitrate which arrests decay. 23,306 first permanent molars and 11,938 other teeth, a total of 35,244 permanent teeth were conserved by the following means:— 1,127 cement fillings, 12,348 amalgam fillings, 20,203 combined cement and amalgam fillings, 4,360 silicate (porcelain) fillings and 590 treatment with silver nitrate. Every child treated had an average of .86 permanent teeth conserved. Other treatments of a varied nature include 273 root fillings, 3,188 dressings, 255 crowns, inlays, etc., 7,650 scalings and gum treatments. Dentures were provided in 281 cases to replace teeth lost by accident or disease, 666 attendances being made for the necessary work incurred in the fitting of these dentures. These figures show a decrease on the figures given in my report of last year due to the reduction in dental officers during the present year. One regrettable reduction is the average number of teeth conserved for each child. Last year this figure was 1.1. This year the figure has fallen to .86. This is largely due to the inescapable fact that many more children have been treated this year for the casual relief of pain when extraction was the only remedy and these extractions have offset the number of fillings which have been done for the routine cases. This is the inevitable result of the unfortunate circumstances under which we are labouring.

In conclusion I should like to say that great as our difficulties have been during the year under review, they would have been very much greater if it had not been for the interest which the Dental Services Committee has taken in the scheme, for the sympathy and understanding of Dr. Broekington, and last but not least for the unfailing loyalty of all my staff from Area Dental Officer to boy apprentice and office boy. This loyalty is to me a great sustaining factor in the midst of difficulties and frustrations.

PART VII

CARE AND AFTER-CARE

The Care and After-care of Hospital Patients

Executive social medicine will experience no greater advance than that which can come from the development of care and after-care, as an expression mainly of Section 28 of the National Health Service Act. This Section said:—

“A local health authority may with the approval of the Minister, and to such extent as the Minister may direct, shall make arrangements for the purpose of the prevention of illness, the care of persons suffering from illness or mental defectiveness, or the after-care of such persons, but no such arrangements shall provide for the payment of money to such persons, except in so far as they may provide for the remuneration of such persons engaged in suitable work in accordance with the arrangements.”

It will be many years before this new work can be fully developed but the year 1949 saw notable advances. The final goal is to bring the resources of the health department to the assistance of all patients in need leaving hospital, to those cared for at home by their own doctors and to the industrial worker. It is in the hospital sphere that most progress has been made. Here we have had to consider the needs of both general and special hospitals, including maternity homes, mental hospitals, mental deficiency colonies, long-stay hospitals for children, sanatoria and hospitals for the chronic sick. Each presents its own peculiar features. In devising machinery to meet this work the first essential has been to establish convenient methods of transmitting confidential information from hospitals to health departments. A start was made with this under the Education Act of 1944 when, in return for payment for free treatments, hospitals agreed to tell us when children were admitted and to give a report of their findings and recommendations upon discharge. This was found to be invaluable in following up our school children and in relating the hospital findings to the school, the home, and eventually in advising juvenile employment committees when the child left to enter industry. The school health record has been more complete in essential details.

The extension of this work to all classes of hospital patient presented such difficulties that it seemed desirable to make small scale experiments. Accordingly, in collaboration with the Rotherham County Borough, an approach was made to the Rotherham and Mexborough Hospital Management Committee and a scheme was worked out, of which details are set out below:—

Agreement reached (August 1949) with a hospital management committee in an industrial area:—

“Memorandum of agreed procedure to be adopted to ensure co-operation between the hospitals administered by the Rotherham and Mexborough Hospital Management Committee and the local health authorities of the West Riding County Council and County Borough of Rotherham in matters relating to the notification of the discharge and the after-care of patients discharged from hospitals, the notification of infectious diseases and of food poisoning, medical reports on school children, and social investigations.

(Note:— (a) Paras. (a) of Sections 1 and 2 below relate to patients residing in the area of the Medical Officer of Health, County Borough of Rotherham, and Paras. (b) of the same sections to patients residing outside the area of the County Borough of Rotherham.

(b) “the appropriate Medical Officer of Health” means the Medical Officer of Health of the Local Health Authority in whose area the patient resides.

(c) the term “hospitals” refers to those under the control of the Rotherham and Mexborough Hospital Management Committee).

1. CASES REQUIRING HOME NURSING.

(a) Except in cases of emergency, at least 12 and preferably 24 hours' notice wherever possible must be given by hospitals to Superintendent Nurse, Home Nursing Service, Rotherham, on application forms supplied to hospitals, of discharge of cases requiring home nursing. Notice of emergency discharges to be given by telephone and confirmed in writing.

(b) Hospitals to telephone West Riding Divisional Medical Officer of Health of area in which patient resides with at least 12 hours' notice of discharge, and 24 hours' notice wherever possible. Emergency discharges to be notified by telephone and all discharges confirmed in writing.

2. EARLY DISCHARGE OF MATERNITY CASES.

(a) Except in cases of emergency, at least 12 and preferably 24 hours' notice wherever possible of early discharge of maternity cases must be given by hospitals to the Superintendent midwife. Notice of emergency discharges to be given to the Superintendent midwife by telephone, and confirmed in writing.

(b) Hospitals to telephone Divisional Medical Officers of Health of area in which patient resides with at least 12 hours' notice of discharge, and 24 hours' notice wherever possible. Emergency discharges to be notified by telephone and all discharges confirmed in writing.

(c) In view of the pressure on maternity beds, normal maternity patients cannot be retained beyond 14 days. If the patient's home conditions on admission are bad, the appropriate medical officer of health will ensure that they are improved before the patient's discharge on the 14th day, or make suitable arrangements for her reception on her discharge, on receipt of notice of discharge from hospitals as provided in paragraphs 2 (a) and 2 (b) respectively.

(d) *Discharge of Premature Babies.* Hospitals should notify the appropriate Medical Officer of Health of the impending discharge of premature babies and ascertain whether home conditions are satisfactory before the child is discharged. General information regarding the child's condition should also be furnished. No premature babies should be discharged unless in a physically fit condition, particularly as regards weight.

3. INFECTIOUS DISEASES.

(a) Notification of undue incidence.

Hospitals should inform the appropriate Medical Officer of Health immediately, *in writing*, of any undue incidence of infectious disease, *whether notifiable or not*, occurring in the hospital. A list of infectious diseases, in addition to notifiable diseases, of which notification is required from hospitals, is attached.

(b) *Discharge.*

The procedure for discharge of cases of infectious diseases is set out in Circular letter SHMC/MO/83, dated 3.1.1949, from Senior Administrative Medical Officer, Sheffield Regional Hospital Board, circulated to Medical Officers of Health and all Hospital Management Committees. The terms of this letter are:—

- (i) When cases of infectious disease are to be discharged to their own homes, the Hospital must notify the Medical Officer of Health of the Local Health Authority in whose area the home is situated.
- (ii) This is particularly important in those cases arising in general hospitals, where it is considered by the Medical Officer in Charge of the case that simple isolation in the patient's own home is all that is necessary. In these cases, it is essential that the home conditions should be known, so that the risk of infecting other members of the household is negligible, and that the patient's condition is not prejudiced. Effort should normally be made to find accommodation in an isolation hospital, where nursing facilities are readily available, for all cases removed from a general hospital.
- (iii) The notification procedure to be followed in all isolation hospitals is that the *Local Authority* must be notified as soon as possible of the admission and discharge of a case of infectious disease.
- (iv) The appropriate Medical Officer of Health will ascertain the patient's home conditions on the receipt from infectious diseases hospitals of the notification of discharge.

4. **FOOD POISONING.**

In order that causative factors may be investigated immediately, all cases of suspected food poisoning or food poisoning should be reported forthwith to the appropriate Medical Officer of Health.

5. **AFTER-CARE.**

All necessary details of cases requiring after-care, to be carried out by the local health authority, should be notified as soon as possible to the appropriate Medical Officer of Health, under confidential cover.

6. **CHILD HEALTH SERVICE—MEDICAL REPORTS.**

In all cases where it is desirable to provide or secure continued medical supervision, special educational treatment, or after-care, for pre-school and school children on their discharge from in-patient treatment or termination of out-patient treatment at Hospitals, the appropriate information as to discharge and medical report should be supplied to

- (1) the Medical Officer of Health, Rotherham, or
- (2) the appropriate Divisional Medical Officer of Health,

as the case may be, *provided that* the previous consent of the child's parent or guardian to supplying this information is obtained by the hospital.

Information as to admission, discharge and medical reports of pre-school and school children should also be sent by hospitals to the family doctors concerned, where known.

7. **PATIENT'S CONSENT TO DISCLOSURE OF INFORMATION.**

The consent in writing of the patient, or the parent or guardian of a child, must be obtained before any information regarding his or her illness and treatment in hospital is furnished to the appropriate Medical Officer of Health, or Home Nursing Service, and such information must be sent under confidential cover.

(Instructions to this effect have been received from the Senior Administrative Medical Officer, Sheffield Regional Hospital Board, Ref. SHMC/MO/109 of 8.3.1949, and circulated to all hospitals together with form of consent for signature by patient, parent or guardian.)

8. **SOCIAL INVESTIGATION FOR HOSPITALS.**

Reports on the home, other social circumstances, and background histories of patients will be supplied by the appropriate Medical Officer of Health, when required to any hospital.

It is regarded as essential that the closest personal relationship and co-operation in health service matters should exist between hospitals and the local Health Authority's services, i.e. Medical Officer, District Nurses and Health Visitors."

Great care has been taken to ensure that the patient's consent is obtained for any information to be given to the health department and also to ensure that nothing should be done for any patient under the care of the family doctor without his agreement. The scheme is operated through the divisional health offices and the following instruction has been issued to them:—

"In all cases (other than maternity cases discharged from Homes before termination of 14 days lying-in) after the first visit and report to the general practitioner, no further visits will be made, or services performed, without the express permission of the general practitioner. He is primarily responsible for the medical care of the patient when discharged from hospital and it is of the utmost importance that he is consulted, and consents to the County services being provided, in each individual case.

Maternity cases discharged home before the end of the lying-in period can, of course, be dealt with as normal domiciliary midwifery cases.

The preceding instruction will not be so interpreted as to prevent the immediate application of the County service in an emergency. A full report of the circumstances, with details of what has been done, should then be given to the general practitioner concerned."

It was early realised that some personal link with the hospital was desirable to supplement the official means of communication. Accordingly, a senior health visitor from the Mexborough area was attached to the hospital in the manner previously devised for Otley hospital in 1947, of which I gave an account in my Annual Report for that year. In this way personal attention to the details for care and after-care begins at the hospital and if necessary at the bedside. The following is a report of the Secretary of the Rotherham and Mexborough Hospital Management Committee on six months' working of this scheme:—

"Miss Simpson, a West Riding County Council health visitor, commenced duty at the Montagu Hospital on 10th May, 1949, and has been attending regularly three half days each week on Tuesday, Wednesday and Friday afternoons. During this time she has visited patients on the wards and on one half-day each week has been available to interview patients' relatives, and deal with any personal problem they may have in their home life which affected the patient's illness, or arising as a result of the illness. The attachment of Miss Simpson to the hospital has been of great benefit to patients and has provided the link between the hospital service and the after-care arrangements of the local health authority, which is necessary to ensure the essential "follow-up" and continued supervision of a patient on discharge from hospital. Cases which required the attention of a Home Nursing Service, the provision of an appliance outside the scope of the hospital service, and rehabilitation were readily undertaken by Miss Simpson and necessary arrangements made. The work performed during the past six months has been greatly appreciated by the medical staff, and the Senior Registrar, Mr. I. H. Meyer, F.R.C.S., strongly supports the continuance of the scheme.

It would be appreciated if the time allocated could be extended to allow for contact being made with the hospital every day. Miss Simpson has stated that she could have done a lot more work if the time had been available. It is considered that this liaison is extremely valuable and should be extended wherever possible.

Details of the work performed by Miss Simpson during the above period are appended:—

60 half-day sessions.

637 Patients in hospital (excluding short term cases.)

141 Interviews.

34 Home visits.

29 Home nurses—arranged for patients after leaving hospital.

19 Home helps, arranged and employed.

20 Home investigations carried out.

3 cases—rehabilitation—change of employment.

(a) 1 very successful—patient co-operative entered training centre, now settled in good employment permanently.

(b) 1 training arranged—after convalescent period completed.

(c) 1 doubtful outcome, patient unco-operative.

7 cases helped through National Assistance.

3 Special appliances supplied—various sources which applied to particular cases.

3 Transfers to open air schools, and 1 pending.

1 Old age pensioner, no abode—transferred to institution.

1. All Gastrics and special diets kept under supervision unless otherwise indicated.

2. Discharges of children and after-care required, are notified to the Divisional Medical Officers.

3. Complete liaison established with Home Nursing Service—in one particular and unusual case 2 Home Nurses were invited to Hospital, introduced to the Ward Sister, also to the patient, and case nursing, etc. discussed, thus ensuring continuance of hospital treatment, and suitable adaptations in patient's own home.

4. Family of 4 children placed in Residential Schools and Nursery, to hasten mother's admission to hospital for Mastectomy.

5. Special Departments contacted, and any problems dealt with.

6. Wards visited thrice weekly."

I give below also a brief statement of the senior surgeon to the hospital of how it works from the point of view of the hospital staff:—

"The Care and After Care Scheme at the Montagu Hospital, Mexborough, has made progress since its start on the 10th May, 1949, when a Senior Health Visitor was appointed as Hospital Health Visitor.

The Health Visitor has attended regularly three half days each week, and the work carried out has been I think very successful. I would greatly appreciate from my point of view, if the time could be extended to allow for contact with the hospital on every day of the week.

The appointment of a Hospital Health Visitor has forged a further link between the hospital and the home, and has been instrumental in facilitating our work in the Hospital in many ways. The main factors are, of course, the assistance provided through the scheme for the follow-up of Hospital treatment in the home, a matter in which I would emphasize the very good work done in the treatment of stabilised diabetics, either by the actual Home treatment by the District Nurse under the direction of the family practitioner, or by teaching and supervision of self-injection.

Other factors are the facilitation of discharge of patients and consequently a quicker turn round of bed vacancies in the hospital. This quick discharge of patients is greatly assisted by the knowledge that home treatment is being carried out under the efficient supervision of Public Health Nurses under the direction of the family practitioner. In addition, the knowledge of environmental and socio-medical conditions, obtained as necessary, by a Health Visitor on the Care and After-Care Form Part A, gives an impartial picture of the home conditions.

The early discharge of maternity cases can also be of great assistance, and information regarding home conditions constitutes to a great measure a guide when cases of this nature are discharged prior to the fourteenth day.

The Hospital Health Visitor has also assisted materially in many other instances of which the following indicate the type:—

Rehabilitation of patients: Several cases necessitating rehabilitation in the form of changes in employment have been negotiated directly and successfully, through the local office of the Ministry of Labour. Also a family of four children have been placed in County Homes to facilitate the mother's admission to hospital for urgent mastectomy; home visits were carried out by the Hospital Health Visitor with regard to investigations required for the provision of Convalescent Home treatment under the Regional Hospital Board; the provision of nursing equipment for the home in a case of spinal paraplegia and the subsequent arrangements for the nursing and occupational therapy; home visits to the aged following discharge from hospital—subject to suitable home condition, following treatment for fractures, and the negotiations with the Local Health Authority for the provision of a Domestic Help.

In conclusion may I add my thanks to the Health Visitors concerned, Miss Simpson and Miss Bailey, and express the hope that, as outlined in my first paragraph, this scheme can be furthered to the extent of allowing a permanent contact to be made with the Local Health Authority through a Hospital Health Visitor each day of the week, as I feel that there is much work that can still be done in this sphere."

In the light of the successful outcome of this trial arrangements have now been made to extend its operation to the remaining hospitals in the group; a senior health visitor of the Rotherham division has been attached for West Riding patients to the following hospitals in the group:—

Listerdale Maternity Hospital.

Oakwood Hall Sanatorium.

Rosehill Infectious Diseases Hospital.

Rotherham Hospital, Doncaster Gate.

Rotherham Infectious Diseases Hospital.

Rotherham General Hospital Moorgate.

Swallownest Infectious Diseases Hospital.

and a health visitor from the Penistone division is similarly acting at the Hallamshire Maternity Home.

Negotiations are now in progress with a number of the remaining management committees which serve our territory with regard to inaugurating similar schemes. These negotiations are not sufficiently advanced for me to report definitely upon their outcome. One in particular shows exceptional promise and points the way to further advances in what is now one of the most pressing problems of the day, namely, the care and after-care of the chronic sick. This is a scheme devised in agreement with the Harrogate Management Committee to attach a senior health visitor from the Harrogate division to the Knaresborough Institution. Under this arrangement admission of chronic sick will be dependant upon an initial socio-medical report upon the home circumstances and Dr. Curtis Bain, who has been appointed in charge of rehabilitation at the institution will have similar aid in the problems associated with the discharge of patients. The operation of social medicine for the chronic sick presents many difficulties but it is already evident that a partnership between the hospital and the health department can offer great new opportunities.

The hospital health visiting, which began at Otley Hospital on 5th January, 1948, has continued in operation with the full support of the management committee. The work has been undertaken in six-monthly periods by senior and experienced health visitors from various divisions in order to spread the value of this experience as widely as possible. Miss Topley replaced Miss Cribb in January, 1949; Miss Baldwin, now Mrs. Wilde, has followed in succession. It is hoped now to establish a permanent link by means of a health visitor from the Otley division. Dr. Hill of Otley Hospital gives the following account of his impressions of two years' work:—

"As you know I have been strongly in favour of this department of the hospital's activities since its inception. The service provides an invaluable link between the hospital and the home and has helped to solve many problems which would undoubtedly have had an adverse influence on the patient's progress in hospital had they remained unsolved.

Since Miss Carey inaugurated the Social Medical Service here I have had a succession of capable and enthusiastic officers provided by you. You will have had various statistical reports from these good people and I have no need, therefore, to go into details of the actual work done, but I can assure you that the services of the Hospital Social Welfare Worker are regarded as invaluable by the Medical and senior Nursing Staff and by the patients. The work, which often includes home visits and liaison with the D.M.O., is time-consuming and cannot be carried out by a member of the usual hospital staff. It has often been noticed that when the Social Welfare Worker has interviewed a patient at the request of the medical staff, several other patients in the same ward have asked for an interview with her and have almost invariably received some benefit. In view of the fact that so often the admission of a father or mother to hospital constitutes a major domestic crisis I do feel that work in this sphere should be encouraged and extended as part of the National Health Service."

The development of care and after-care in relation to hospitals has arisen from the realisation that diagnosis and treatment in hospital are not enough. The illnesses of all ages and classes are often closely related to the circumstances of life and work in the community. These circumstances must be attended to if the benefit from hospital care is to be maintained. The weakly or premature infant cannot survive in a bad home and before its discharge the health department must have an opportunity to put things right or find alternate means of care; the child handicapped by epilepsy, heart disease, diabetes, deafness, crippling defects, or indeed in any manner, must be assured of special arrangements for education and continued supervision at school; mothers going out of a hospital or maternity home before the 14th day will need the care of a midwife at home; many of those who have had operations and others will need special nursing care by a home nurse who must be made familiar with what is required; many adults suffering from permanent handicaps must have assistance in overcoming them and guidance to find suitable employment; the chronic sick, particularly when age is beginning to tell, and many other hospital patients have home worries and home problems for which an answer has somehow to be found and for which the medical officer of health, either in his work for the County or possibly for the County district, may with the assistance of his team be able to find an answer; it may be the state of the house or the drains, or overcrowding, or the rapid growth of a young family or lack of domestic help, or there may be bad parental management, faulty housekeeping or hygiene at the root of the trouble; the possible contributory causes of illness and ill-health are, of course, very great indeed but whatever they may be the object of this scheme is to ensure that the health department in full collaboration with the doctor shall help to remove them.

Tuberculosis

The care and after-care of patients with tuberculosis (now increasingly possible under S. 28 of the Act) will be an effective weapon in our fight against the disease. However, there is little new to report for the year under review. We are still faced with the problem of caring for the patient for whom institutional accommodation cannot be provided. In this we have been helped by the deployment of the resources of the Home Nursing and Home Helps service. A home help has to volunteer before being assigned to such work but even when she has done so it is disturbing, from the point of view both of a Local Health Authority and of an Employer, to expose her to a known risk without ensuring that she is not peculiarly susceptible to the disease, a matter which can only be resolved by examination including an X-ray of the chest. Nevertheless the work is being done and every other possible precaution is taken.

Extra Nourishment—The provision of extra nourishment continues to be regarded as a valuable adjunct in the care of the tuberculous. It is authorised for issue where necessary on the scale of two pints of milk daily to all cases of active tuberculosis certified as such by the Chest Physicians employed by the Regional Hospital Boards. Grants are approved for a period of two months and then subject to review. The number of patients in receipt of extra nourishment increased from 470 at the beginning to 627 at the end of the year and were being provided with this benefit at a cost of approximately £7,000 per annum.

Domiciliary Open Air Shelters—Despite the acute housing situation and the lack of institutional accommodation the use of the open-air chalet, or sleeping shelter, designed to provide separate and healthy sleeping accommodation for the patient at home, has lost much favour. The purchase of twelve new shelters in 1936 increased our stock to 97, all of which were in use and in ready demand. We now have 44 remaining and are unable to keep this number fully occupied.

Rehabilitation—The rehabilitation of the tuberculous patient involves not only physical rehabilitation but the restoration of the patient to the community. In its ideal form the patient is able to return to his own home and to resume his former occupation. If it is inadvisable for him to return to his former employment a suitable alternative occupation has to be found and, if necessary the requisite training undertaken. In all cases the work done should be limited to the physical capacity of the patient. In the present day of full employment these categories present few problems and are dealt with by close co-operation between the Chest Physicians, the Divisional Medical Officer, the Ministry of Labour and National Service with the facilities afforded by the Disabled Persons Employment Act and the use of *Remploy* factories, and representative organisations of employers and employed.

There remains the hard core of the chronic infectious case needing sheltered employment and for this group there is at present no satisfactory solution. The most successful method of dealing with these cases is well illustrated by the industrial settlement at *Papworth* and in a more restricted field at *Preston Hall*. These admirable institutions continue to be available for West Riding Patients but the number of cases, both clinically suitable and willing to "emigrate" from the environment of their home and locality, are very few. It may be that greater use would be made of similar facilities provided in the County area. A more local centre is the *Sherwood Village Settlement*, Rainworth, near Mansfield, which is at present operated by the Nottinghamshire County Council and is to serve the area of the Sheffield Regional Hospital Board. Negotiations proceed for our full participation in the use of this centre.

West Riding Distress Fund—For many years it has been possible for the tuberculous patient to obtain a grant from this fund to meet expenditure of a special nature and for which no other source of assistance was available. With the operation of the new Social Legislation special consideration was given to the further use of the fund and it was agreed by the County Council that applications might still be submitted in respect of relatives travelling expenses to visit patients in sanatoria and for the provision of pocket money in a limited number of cases.

Applications for beds and bedding, formerly provided, are no longer submitted as, if required for the home nursing of the patient or to enable an infectious patient to sleep alone, they may now be issued on loan from the equipment provided for home nursing.

Recuperative Homes

General convalescence is provided by the County Council as part of the after-care service and, so that it might be readily distinguished from convalescence as a continuation of hospital treatment, is referred to as recuperative home treatment. It is available for all persons on the production of a satisfactory medical certificate and subject to the elimination of any question of treatment, this latter being the responsibility of the appropriate hospital authority. The beneficiaries are assessed for contributions towards the cost according to their financial circumstances.

Confusion has been caused by the competing claims by Regional Hospital Boards and Local Health Authorities for the use of available convalescent accommodation. At one stage it was suggested that the residue would be available for Local Health Authorities after the Regional Hospital Boards had made their selection. The situation is still vague and until it is resolved there would seem to be no useful purpose in preparing a special County Service. Use is made of the available Homes which are generally managed by Voluntary Agencies whose terms, regulations and waiting lists vary considerably.

Convalescence is normally for an initial period of 2 weeks in each case, subject to extension on further medical certification. During the year under review 233 applications for convalescence were approved and admitted to the following Homes:—Blackburn and District Convalescent Home, St. Anne's-on-Sea; Boarbank Hall, Grange-over-Sands; Brentwood Recuperative Centre, Marple, Cheshire (a special Home where convalescence is combined with the teaching of household management and where the mothers are admitted with their children); Faith House, Devon; Horncliffe Convalescent Home, Blackpool; Hunstanton Convalescent Home, Norfolk; Macclesfield Convalescent Home for Children; Manchester & Salford Convalescent Home, Southport; Men's Convalescent Institution, Rhyl; Marfa Hall, Rhyl; North East Counties Friendly Societies Convalescent Home, Grange-over-Sands; Rechabites Memorial Home, St. Anne's-on-Sea; "Rest" Convalescent Home, Portheawl; Rockfield Convalescent Home, St. Anne's-on-Sea; Sefton Convalescent Home for Babies, Birkenhead; Semon Convalescent Home, Ilkley; Sheffield Children's Holiday and Rest Home; West Kirby Children's Convalescent Home, Wirral, Cheshire; Yorkshire Home for Mothers and Babies, Harrogate (exclusively for post-natal cases, usually accompanied by the babies).

Towards the end of the year it was agreed that children of school age should be provided with convalescence under the provision of the Education Act and they are no longer afforded similar facilities under the general arrangements for care and after-care.

Health Visiting

The work of the health visitor during 1949 has been gradually changing along the lines mentioned in previous reports. Among much else in many areas health education in schools (film shows and talks) has been developed. The health visitors have also co-operated well in the programme for care and after-care of sick patients and seem to be enjoying their new contacts. The care of the aged has also opened up a new field of work, which is slowly developing. Thus, the health visitor has shown herself to be a capable socio-medical worker, aware of the many complicated problems within the family group, and she will increasingly act as the focus of such work. She is a family adviser in day to day problems of physical and mental health.

The number of health visitors has increased by 20, as follows:—Appointments: (a) from County Council's Assisted Training Course—33; (b) from other sources—by advertisement etc.—16. Losses: (a) Retired—11; (b) Died—2; (c) Married—4; (d) Transferred to other Authorities—10; (e) Transferred to industrial nursing—1; (f) Dismissed—1. This substantial increase has been a welcome improvement but it leaves our service still much below establishment; moreover, the 33 students were only just sufficient to meet the heavy loss of 29 and the final increase depended upon recruitment of trained staff. This is the second year of our student health visitor training scheme (with Leeds University); three of the nurses who left during the year were students in 1947-48. At the end of the year we had 187 fully trained whole-time health visitors (compare last year 169) against the approved establishment of 317. To make up for this deficit there were employed 5 part-time qualified health visitors; 56 whole-time and 18 part-time State Registered nurses without a health visitor's certificate. Additionally, health visiting duties were being undertaken by 11 of the home nursing staff.

Thus, there is still a fair amount of work done by assistant health visitors. Although, however, the majority of these are State Registered nurses and midwives and able to do excellent work in a limited capacity in schools and clinics they cannot visit homes and they should be discontinued as soon as possible. Until fully qualified nurses are available we hope to employ only those who are willing to take the Health Visitors' certificate.

Two divisional Superintendent Health Visitors were appointed in September, 1949. There is a need for these appointments in each large division; they are invaluable in organising educational work both in school clinics and amongst the nurses, in acting as a liaison officer between various nursing staffs and thus helping each division to work as a whole, in keeping up a high standard of performance, and in working between the hospital and divisional office in the care and after-care programme.

Miss Clarke has still been retained as Tutor to the student health visitors by Leeds University. Thirty-one students entered for the nine months' course finishing in July, 1950; all students from the previous course passed. Miss Clarke has arranged field work for students in divisional areas within easy reach of Leeds; in these areas Divisional Medical Officers have helped greatly and health visitors have acted as field tutors. Miss O'Brien has continued her work with problem families; early in the year she completed the survey described in the last report; since then she has helped to complete the ascertainment of all families in the West Riding and has visited each family before its inclusion in the register; this work progresses satisfactorily (see page 74). Miss Carey has continued with the work of arranging care and after-care in relation to hospitals (see page 67). She has also commenced an investigation into the care of epileptic patients and their rehabilitation (see page 48). The development of these special functions has cut down the work of supervision and organisation by the three Area Superintendents (Miss Clarke, Miss Carey and Miss O'Brien) but it is hoped that the detailed supervision provided by the divisional scheme compensates for this.

37 members of the health visiting staff attended post-certificate training courses organised by various approved bodies, as follows:—

Women Public Health Officers' Association. London: 5th-9th April (3); Cambridge: 25th June—9th July (9); Cardiff: 10th-24th September (5); Cardiff: 13th-17th September (Superintendents' Course) (2); London: 30th December—13th January, 1950 (8).

Royal College of Nursing. London: 19th-30th April (6).

Tuberculosis Educational Institute. Bath: 25th-29th April (3).

Central Council for Health Education. Eastbourne: 28th July—11th August (1).

Health visitors also attend monthly conferences at Wakefield on particular aspects of their work. The lecture programme for the year 1949 was as follows:—January: Mental Deficiency—Dr. H. J. O'Loughlin, Medical Superintendent, Oulton Hall. February: Breast Feeding (preceded by a film display "Science of milk production")—Dr. C. C. Harvey, Paediatrician, W.R.C.C. March: West Riding Foot Survey (illustrated)—Miss Bradley, The British Boot, Shoe and Allied Trades Research Association. April: Public Health in America—Miss D. Walker, Superintendent Health Visitor, W.R.C.C. May: The Public Health Nursing Service—Miss D. Walker, Superintendent Health Visitor, W.R.C.C. June: Common Diseases of the Ear, Nose and Throat—Mr. J. E. Rees, Hon. Surgeon, Harrogate General Hospital. July: Some Modern Aspects of Tuberculosis—Dr. B.T. Mann, Consultant Tuberculosis Officer, Regional Hospital Board. October: Care of the Unmarried Mother, Miss M. D. M. Mitchell, Senior Health Visitor for the Care of the Unmarried Mother, W.R.C.C. November: Speech Therapy—Mrs. J. E. Moss, Speech Therapist, Leeds General Infirmary.

Home Nursing *

At the end of the year 272 District Nurses were employed as follows:—

2 Superintendents of Queen's Nurses Homes.

166 undertaking General Nursing only.

93 undertaking General and Midwifery duties, and

11 undertaking the combined duties of General, Midwifery, Health Visiting and School Nursing.

The Home Nurses paid 604,154 visits to 27,603 patients classified as under:—

MEDICAL (18,563 cases).

Senility	1,441	Anaemia	388	Rheumatism	642
Cardiac	1,849	Influenza	295	Fractures	345
Cerebral	1,815	Bronchitis and Asthma	904	Constipation	1,270
Pneumonia and Pleurisy	992	Mental Defectives	14	Tuberculosis	199
Intestinal Obstruction	237	Kidney conditions	143	Gynaecological	985
Diss. and Arterio Sclerosis	84	Carcinoma	1,215	Miscellaneous	4,027
Diabetes	575	Threadworms	614		
Infectious Diseases	124	Skin conditions	405		

SURGICAL (8,478 cases).

Empyema	23	Minor Accidents	1,157	Colotomy	192
Burns and Scalds	844	Varicose ulcers	448	Supra pubic	167
Post operative	1,736	Tuberculosis	2	Circumcision	1,158
Septic Conditions	2,604	Gangrene	89	Miscellaneous	58

(Abscesses etc).

EYES AND EARS (562 cases).

Eyes	171	Ears	391
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The Home Nurse-Midwives attended 1,831 cases of confinement (1,224 as midwives and 607 as maternity nurses), to whom 28,395 visits were made; in addition, 16,121 visits were made to ante-natal cases.

Home Nurses undertaking health visiting and school nursing duties in the rural areas of the County made 9,584 visits as health visitors and 697 visits as school nurses.

Many of the cars purchased from the Nursing Associations are now in need of replacement. Of the 272 Home Nurses employed 69 were using motor cars provided by the County Council and 117 their private motor cars on County duties. Of 82 new motor cars ordered, only 16 have so far been delivered.

The re-organisation of personnel is proceeding satisfactorily in the divisions and will be reported in more detail next year. In some of the areas nurses are undertaking services to patients which were previously given by the General Practitioners and this applies particularly to the under-doctored areas; furthermore the district nurses are now being required to nurse a larger number of patients suffering from tuberculosis and their duties in these cases have been extended to include the administration of streptomycin. As mentioned earlier in the report the number of domiciliary confinements has declined. The effect of this is that where a nurse is doing combined nursing and midwifery duties she is now able to devote more of her time to the former. Introduction of new drugs has reduced the length of time in which patients are confined to bed thereby shortening the duration of actual nursing attendance required.

Training of Student District Nurses—Under the arrangements made with the Queen's Institute of District Nursing, 15 students were trained during the year.

* All non-monetary assets of the various Nursing Associations were in the process of being purchased at an agreed valuation, and the position is as follows:— *Houses and/or Nurses Homes*: Purchase completed 20 (12 furnished, 8 unfurnished); Negotiating to purchase 11 (8 furnished, 3 unfurnished); Rented from owners 58 (21 furnished, 37 unfurnished). *Furniture and Furnishings*: Purchased 39; Rented 2. *Motor Cars*: Purchased from D.N.A.'s 48 (2 re-sold; on loan from D.N.A. 1; new cars 16; second-hand cars 6. *Garages*: Purchased from D.N.A.'s 14; rented from owners 46.

Home Help Service

The home help service established under section 29 of the National Health Service Act, has concluded its first year of operation; it began slowly, but as the public became aware of its existence and appreciated the benefit which could be derived from it, the demand rose steeply towards the end of the year so that on the 31st December 739 part-time home helps were being employed, representing the equivalent of 291 whole-time employees against an establishment of 310 whole-time home helps. This rapid growth shows a real need for help in keeping homes together under the increasing strain of industrial life, coupled with an ageing population. It is certainly in the spirit of social medicine that the need should be satisfied, for a healthy community depends upon a healthy home life. Experience has shown that if the service is to be provided on a scale in keeping with the spirit of the Act there will be the need for a large increase in the establishment. There is a steady demand from the aged and chronic sick and to help with general nursing; but some calls upon the service are seasonal in nature and dependent upon prevailing epidemics. This variable demand has been one of the difficulties to be found in the early stage of development when the approved number of home helps has been small. Perhaps the outstanding fact which has been learnt during the first year of operation (about a service which will eventually be one of our greatest social services) has been how closely it is related to other problems of social medicine. Where there is need for a home help there is usually need for other forms of socio-medical guidance. Health visitors have found that their visits to the homes of those applying for home helps present them with great new opportunities to teach health and to remedy social deficiencies, and the divisional medical officers have, in their turn, found it possible to study the family and to bring relief in many ways. One of the advantages of this close study by the divisional health office has been seen as the year progressed in the more accurate assessment of work and the more economical use of home help time.

The chronic sick and the aged present peculiar difficulties since the period for which home help may be required is quite indefinite; it often happens that the withdrawal of help leads to a breaking up of the home and removal to an institution. Old age in itself is not necessarily a handicap and the promotion of a healthy old age (Eugeria) must be one of the objects of our health departments; yet degenerative disease or the infirmity of senility are generally permanent and progressive so that, in terms of the home help, this period of life will certainly make increasing and heavy demands on our service.

The following statement gives an analysis of the cases attended by home helps for the period 1st April to 31st December, 1949:—

	Number of cases.				
Illness	1,362
Lying-in	1,759
Expectant Mothers	175
Mental Defectives	9
Aged	642
Children of School Age	64
Total	<u>4,011</u>				

Removal to Suitable Premises of Persons in need of Care and Attention

Section 47 of the National Assistance Act, 1948, provides that where a Medical Officer of Health of a county district certifies that a person is suffering from grave chronic disease or being aged, infirm or physically incapacitated is living in insanitary conditions and is unable to devote to himself, and is not receiving from other persons, proper care and attention the County District Council may apply to a court of summary jurisdiction for an order to remove the person to a suitable hospital or other place and be maintained there.

Dr. M. Hunter, Divisional Medical Officer, and Medical Officer of Health for the Urban Districts of Barnoldswick, Earby, Silsden and Skipton, and the Rural District of Skipton, states that action under Section 47 "has not been taken, as alternative methods of dealing with the few cases coming to notice were found practicable and preferable." Dr. N. V. Hepple, Divisional Medical Officer, and Medical Officer of Health for Ripon City and Ripon and Pateley Bridge Rural District comments that "action under Section 47 is a slow process. The procedure is useless in cases of emergency, where old people are ill and uncared for, and refuse to go into a hospital or other place where care can be provided. If any permanent improvement in conditions can be obtained, it seems to me to depend entirely on what can be done to provide better housing and to obtain assistance in the house for these people. Removal for a few months is no solution of the difficulty, but does provide a time for other actions to be taken." Dr. F. Appleton, Divisional Medical Officer, and Medical Officer of Health for Brighouse B. and the Urban District of Elland writes:—"Although in this Division no action has been taken under Section 47, the powers thereunder have been delegated to a Sub-Committee so that action can be taken promptly in case of need. The Section has been used on several occasions in a negative way as a last resort by telling persons who were recalcitrant, and for whose sake or for the sake of others removal was urgent, it would be necessary to take action under the Section. In this way the persons have been persuaded to take the accommodation offered. In addition, of course, there are cases where the approach, in conjunction with the medical practitioner, has resulted in the removal of patients without the use of Section 47."

Three men and 11 women were removed to appropriate accommodation under Court Orders obtained in accordance with the provision of Section 47. The hearing of 1 application for an Order in respect of a man was adjourned by the Court for a month during which time certain local residents cleaned up the man's accommodation to such an extent that at the further hearing by the Court the application had to be withdrawn. The man is said to be again living in unsatisfactory circumstances. In a few other cases in other areas the initiation of action under Section 47 was sufficient to secure voluntary removal to an institution or care by relatives.

Orders authorise a person's detention for any period not exceeding three months but the Court may from time to time by Order extend that period. Extensions were applied for and granted in respect of 2 men.

Problem Families

This is a problem in social medicine which clearly presents unusual difficulties and there is little likelihood of finding any standard answer. In view of the importance of the problem family as a cause of the homeless child, delinquency, illegitimacy, dirt diseases, educational sub-normality, mental deficiency, and infant mortality, some addition to our existing resources for combating the condition is, I fear, essential.

Last year I gave an account of our work in a pilot survey, organised by the Eugenie Society, as to the best means of ascertaining the problem family. This survey revealed that the most reliable source of information is the health visitor. This year ascertainment has continued but our knowledge of the incidence of these families in the West Riding cannot yet be regarded as complete. The following table indicates the extent of our knowledge at the end of the year:—

Division.	Number.	Division.	Number.
1	12	21	7+12 to be investigated.
4	19	23	26
7	13	24	1
8	7	25	12
9	17	26	21
10	9	27	11
11	46	28	16
13	17	30	27
16	12	31	86+61 to be investigated.
17	15		
18	26		
19	17		
20	14		
			431+73 possible.

Miss O'Brien, Area Superintendent Health Visitor who undertook the field work in the pilot survey, has continued to give personal attention to the details of each family and Divisional Medical Officers are studying the circumstances of each case with the object of effecting such measure of rehabilitation as their existing resources permit. The following case notes are illustrative of the work:—

CASE A. I think this is a very interesting case as it demonstrates so many points that I feel to be typical of the disease, and the value of an experienced Social Worker. The following are points which I feel worthy of note.

1. A low level of intelligence in both parents and in all of the family. They probably all come into the category of dull and backward.

2. As to character easily led and irresponsible and hence also reasonably amenable to discipline so long as someone is standing over them, e.g., the children have done quite well in the various establishments to which they have been sent. A local resident tells me that the father was not too bad in the Army (he served with him in his Regiment), and the mother will always respond temporarily to prodding by a good Social Worker.

3. A large family conceived at short intervals thus weighting the scales against the family both financially, and in regard to the mother's health, the care which she has been able to devote to the children individually, and her ability to cope with the disciplining of the children. I feel that since her hysterectomy an element of fear and uncertainty has been removed from the mother's mind. Perhaps adequate birth control advice in the early stages would have helped a lot.
4. Housing. This family have undoubtedly improved since improvement in their housing has been effected even although the increased rent is a serious economic factor.
5. The husband's consumption of beer and tobacco, although more than the family can afford, I do not consider to be an unreasonable requirement for a working man.
6. In the Welfare State much responsibility is placed on the individual to ensure that Income Tax deductions, Family Allowance, etc., are properly claimed. These types of persons cannot adequately look after their own affairs in this respect. During the period that the Family Allowance Books were being adjusted and Income Tax being deducted at the rate for a single man this family could easily have relapsed into debt again.
7. Personally I feel that in this case Police and School Attendance Officers became tired of the family and visits from officials ceased to mean anything other than prospective punishment.
8. I feel it has undoubtedly been an advantage both to the family and to the children concerned, that having reached the age of about 10 to 12 years, three of the children were removed to institutions for corrective training.
9. The following official and unofficial bodies have been concerned in the treatment of this case, most of them helpful: (a) Medical Officer of Health, (b) Health Visitor, (c) School Attendance Officer, (d) School teacher, (e) Police, (f) Member of Parliament, (g) N.S.P.C.C., (h) Town Treasurer, (i) Housing Manager, (j) Housing Committee, (k) Forget-Me-Not League, (l) W.V.S., (m) Child Guidance Clinic, (n) Welfare Officer, (o) Juvenile Courts, (p) Neighbours.
10. I feel that the outlook for this family is, on the whole, good as long as we continue to stand behind them. The children who are away from home should be employable eventually. The mother is unable to have any more children and I think that very gradually they are losing the feeling that every hand is against them and they are realising that they have friends who will help them provided they make some sort of effort themselves.

The family consists of:—Father and mother and seven children.

This family can be described as an almost typical problem family, the one saving grace is that they are reasonably clean, and although they have had many setbacks they have never sunk into the filthy state which is often the most noticeable characteristic of most problem families. The whole family is slightly below average intelligence, neither the mother nor the father have any idea of how to organise their lives; they cannot look ahead, and take each day as it comes.

The family have been known to the Health Department since 1936 and I have known them personally for about four years. Although I was health visiting in other districts prior to the end of 1945 I have heard all about the family from other sources. The parents had been fined for not sending the children to school regularly. The N.S.P.C.C. Inspector had been visiting the house because it had been reported to him that the parents were going out at night to public houses and leaving the children alone in the house. One child had fallen into the fire and been very badly burnt on the chest and arms one time when the children were left alone in the house. The father was in the Army during the war and overstayed his leave a few times and had to be taken back by the Military Police. Once he was back with his unit he worked quite well under supervision.

When I first started visiting the family towards the end of 1945, they were living in a back to back, one up and one down, house. The house was very poorly furnished. Downstairs was a table, four chairs and a small sideboard, upstairs was a single bed, a three-quarter bed and a baby's cot, the two elder boys slept in the single bed, the baby in the cot and the rest of the family in the other bed and on the floor. They had only four blankets and used old coats for bedclothes. I was told the family had been helped many times, but that they always sold or pawned anything which was given to them. The father was still in the Army so that the mother was assured of a regular income. I found her quite an amenable person who never refused me admission to the house. If the children needed any treatment for minor ailments she would always bring them to the clinic.

The father was discharged from the Army at the end of 1946. He proved to be an idle, irresponsible lout of a man who resented anyone in authority visiting the house and frequently was very rude to me and ordered me not to visit the house again. He could not be relied upon to keep in regular employment for more than a few weeks at a time. Consequently the mother was continually applying to the National Assistance Board for help to feed and clothe the family. The Divisional Welfare Officer had many talks with the father and tried to show him his responsibilities with regard to his family but it was all to no avail, and he was sent to prison twice within eighteen months for failing to maintain his family, and they became a still greater care on the National Assistance Board. However, in October, 1947, he got a job as a labourer with the firm of builders who were building Council houses and appeared to settle down fairly well to outdoor work.

His wife was pregnant again by this time, and was very upset because she couldn't see how she was going to manage with another baby. The husband kicked her down the bedroom stairs once and I think she secretly hoped the child would be stillborn.

The eldest boy was now in trouble with the Police; he had been caught breaking into premises. He was brought before the Juvenile Court and put on probation. The father changed his job again and this time went into a mill. He worked quite well until his wife went into hospital to have the baby, leaving him at home with one child; the other children went to cottage homes. He broke open the gas meter at home, took all the money out of it and took the child off with him. The Police soon traced them and brought them back again. They were charged at Court and the child was sent to an Approved School until he was fifteen years of age, and the father to prison for three months. Once more the family came under the care of the National Assistance Board. The family had been brought to the notice of the Police so much during the past few months they could not forget them, and if any small thefts or misdemeanours were reported their house was the first place where they made enquiries, so much so that the mother finally swore at them and she was charged at Court for using bad language and put on probation.

The father returned home and went to work on the housing estate again; he appeared to be somewhat subdued. The mother became ill with bronchial asthma. A daughter was looking after the family, very inadequately, and we offered the services of a Home Help, but her mother said she would be ashamed to let a stranger come into the house. We tried to get the children into homes, but there were no vacancies, so the father stayed at home again. The Divisional Welfare Officer managed to find homes for the children in about fourteen days, and the mother went to hospital. She remained there about two months. When she had the last baby she was told she would have to return at a later date for an operation for a prolapse, etc., so when her bronchial asthma was better she was persuaded to stay in hospital and have the operation. In view of the number of children she had and the severity of the prolapse, the surgeon did a hysterectomy.

By the time she returned home again her sister and family who lived next door had been given the tenancy of a Council house. She was very envious when she went to visit them and wished she too could have a Council house. At first the Housing Committee would not consider their application—most of the members of the Committee had heard of the family's misdoings, but gradually the Medical Officer of Health persuaded them into giving the family a chance as he felt they might improve if they were given a decent house and something to live for.

The family moved into a Council house. Their furniture, bedding, etc., was, of course, totally inadequate. I gave the Medical Officer of Health a detailed list of everything they possessed and we discussed the various channels through which we could get help for the family. Finally the "Forget-me-not Fund" (a fund started during the war to help servicemen and their families) agreed to spend up to £50 on them, providing we would accept the responsibility of ensuring the goods bought were not sold or pawned. They bought linoleum for the floors, sufficient beds and bed clothes and a chest of drawers. The mother really was grateful for all that was being done for her. She agreed to pay a small amount each week towards the cost of the things. The trustees of the fund did not want the money but we felt it was advisable to let her feel she was helping to buy the things herself.

Meanwhile the children were in trouble with the Police again. They had never had any real possessions of their own and as two of them were growing older temptation was proving too much for them. The son took a bicycle from outside a shop and rode it round the town for an hour or two. The daughter took a doll's pram from outside a house and sat with it in the park. She, too, took a bicycle and rode it up to a relative's house. Three of them took torches and fireworks from a scout hut. The girl was also very unhappy at school and was playing truant a lot. When these things were reported the Police enquiries were invariably made at the family house and after questioning, the children owned up. They were brought to the Juvenile Court and put on probation. The Medical Officer of Health decided that as the girl was so unhappy at school he would give her an intelligence test and try to get her away to a special school. He felt she was probably not as educationally sub-normal as she appeared to be. She had missed a lot of time at school when she was burnt and she was in hospital a long time having skin grafts. Her I.Q. was 77. She was sent to see a psychologist who saw her twice and then recommended that she should be admitted to a Hostel for maladjusted girls.

The fact that he had been before the Court and was on probation did not mean a thing to the son and he continued to "borrow" bicycles and go for rides on them. One day a policeman caught him taking a bicycle back to the house where he got it from. Meanwhile the girl was in trouble about a dress which she said one of the girls at school had given her. The girl, who was of very low intelligence, denied having given it to her and said she had stolen it. The dress was taken home and her mother hid it upstairs instead of taking it straight back to the other girl's house. The Police came to the house enquiring about the dress. The mother first denied having seen it and then produced it from upstairs. The son and daughter were again brought before the Juvenile Court and charged with pilfering. This time the mother herself was charged with being a receiver of stolen goods. The Police had issued a summons against her only the evening before she was due to appear in Court, so that she was quite undefended. The boy was sent to an approved school until he was 15 years of age. The Magistrate allowed the girl to go to the Hostel for maladjusted girls as she had already been recommended for admission. The mother was sentenced to three months imprisonment, because, apart from the charge, the

Magistrate said he did not consider she was a proper person to bring up children. The father was left alone at home and the children all went to Local Authority Homes.

The family had lived in the Council house about seven months by this time. The father had changed his job again, but he was working fairly regularly, he had occasional days off when he felt like it, but they had managed to live on his wage and pay 17s. 10d. per week rent and rates regularly. When his wife went to prison he had all his wages for himself. He went out every evening, presumably enjoying himself. He got into debt at the butcher's, the grocer's, with the milk man, failed to pay the insurance and club money and got four weeks behind with the rent. He did not write to his wife or go to see her, although she was near, and she wrote to me to ask if I would go to see if he was still at the house. As a result of my visit he did manage to write once. One of the neighbours, and her husband, were very good to him and they had him in to their house several times to meals and did his washing and housework for him. The husband offered to help him to do a bit of decorating at home ready for his wife's return, but he never got anything done. His wife returned home after two months; she had been allowed one month remission of sentence because of good conduct.

Just before she returned home her husband was in trouble at his work. He and another man took materials valued at £16 from their employers to do a private bit of work. The matter was not reported to the Police but their employers stopped the money out of their wages. I think he was given his notice as a result of this because he left the firm soon afterwards. He had a few days off again while he was looking for another job and his wife was left without any money to buy food for the family. She had paid £2 towards the cost of the things the Forget-me-not Fund had given her, so, with the consent of the Medical Officer of Health, I gave her this money and she was able to manage for a week. Her husband finally got work as a labourer with the Local Authority's Highways Department. The wage was not high—only £5 3s. 2d. per week but he liked the work and it was very satisfactory from the Council's point of view because he agreed that the rent and rates should be kept out of his wages each week. He was not really earning sufficient money to keep his wife and family. I helped the mother to make out a budget for the family and we found the bare necessities of life amounted to £4 12s. 4d. per week and she said her husband spent at least 14s. per week on cigarettes, which meant they were really living beyond their income all the time. However, she did a bit of washing for a family which brought in about 5s. per week. She took in two young men boarders, fellows who were working with her husband and had nowhere else to go. She managed quite well with the money they paid her and cleared off all the debts which her husband had accumulated and even managed to get a little more furniture for the house. The Housing Manager knew about the boarders, but decided to let them stay for the time being.

Trouble then arose with the husband. When he left his last employment the proper income tax returns were not sent to the Council, consequently the Treasurer's Department kept income tax out of his wage as if he were a single man (11s. per week). This upset him very much. The Medical Officer of Health spoke to the Treasurer several times about the matter but nothing could be done until the appropriate returns had been received. We were afraid he would throw up his job in his usual way, he nearly did, but fortunately both the Housing Manager and myself happened to call at the house when he had been away from work two days as a protest against the stoppage of income tax, and he said he was going to look for another job as he was fed up with the Council. We both talked to him and pointed out his responsibilities to his family and he went to work the next day. While there was all this upset about the income tax his wife was not receiving any family allowance. The book had been sent to the Ministry of National Insurance in Newcastle when she went away. I asked her about it each week when I called, but she didn't know how to get the book back again. I rang the Divisional Welfare Officer up and asked if he could do anything about it. He got in touch with the Ministry and they sent a complicated claim form to her which she could not interpret, so I filled it up and sent it back for her. Finally she got the book back more than three months after she came out of prison. There was £14 to draw, so I suggested to her that she should let me help her to spend the money on clothes for the children. She agreed to this and I took her shopping and spent £9 altogether. She has agreed to let me keep the family allowance book so that she cannot draw the money each week and squander it. The money will be left in the Post Office and will probably be drawn out each month.

This brings us up to the present time. I visit the family each week and write a short report in the problem family book, and report to the Medical Officer of Health frequently. The girl has been home for Easter. She is looking very well and appears to be happy. I have had two letters from her since she went to the Hostel, her writing and spelling are improving very much and she writes quite a nice letter. Two boys have not been home for Easter. I think there has been a bit of trouble at their schools—some of the boys have been trying to run away. They both write home each week, one writes a fairly good letter but the other is somewhat incoherent. Their mother usually gives me their letters to read. One boy got about 50% marks for most subjects except history and economics. They were very poor, and I am afraid he will have the same difficulty organising his life as his mother and father have. Another boy and a girl are attending school fairly regularly. The two youngest children are quite well nourished and are usually clean when I call. The house is usually quite clean and the mother is taking a pride in her home and possessions. She still has the furniture, etc., the Forget-me-not Fund provided. I have helped her to make-over two garments for the children and shown her how to knit socks, but to teach her this type of thing more than one visit a week is really needed.

The father's income tax is now settled and if he will only continue in regular employment and keep out of trouble we may begin to see a definite improvement in the family.

PART VIII

COUNTY AMBULANCE SERVICE

The service is under the charge of Mr. V. Whitaker, County Ambulance Officer. The approved scheme under the National Health Service Act, 1946 has continued with progress. During the past twelve months, five local authorities' Ambulance Services have been absorbed into the County scheme, and three new depots have been opened. Below are set out the depots now operating under the direct control of the County Council:—

Bentley—Yarborough Terrace, Doncaster; Birkenshaw—Oakroyd Hall, Birkenshaw; Boston Spa—Bramham House, Boston Spa; Brighouse—N.F.S. Station, Halifax Road, Brighouse; Goole—Highways Yard, Dunhill Road, Goole; Guiseley—White Cross, Guiseley; Harrogate—Leadhall Grange, Leadhall Drive, Harrogate; Hoyland—Swallow's Garage, Hoyland, Nr. Barnsley; Huddersfield—Springwood Street, Huddersfield; Keighley—Victoria Hospital, Keighley; Kippax—Cockram's Buildings, Butt Hill, Kippax; Maltby—80, Morrell Street, Maltby; Pudsey—Westroyd House, Farsley, Nr. Leeds; Settle—Cammock Lane, Settle; Shipley—County Fire Station, Shipley; Skipton—Burnside House, Skipton; South Kirkby—Church Street, South Kirkby; Wakefield—York Street, Wakefield; Wath—Dunford House, Wath; (Sub-Depots) Kiveton Park—Wales Road, Kiveton Park; Penistone—The Studio, Shrewsbury Road, Penistone; Rossington—45, Grangefield Avenue, Rossington; Rothwell—ex Fire Station, Church Street, Rothwell.

Ambulance services operated by local authorities and voluntary organisations on an agency basis to be incorporated when suitable depot buildings become available are:—

Barnoldswick U.D.C., Cudworth U.D.C., Castleford U.D.C., Earby U.D.C., Featherstone U.D.C., Holmfirth U.D.C., Knottingley U.D.C., Morley B., Pontefract B., Todmorden B., St. John Ambulance Brigade at Ripon, Sedbergh, Selby, Grassington and Pateley Bridge, and Royston Motor Ambulance Committee.

Thirty-nine new ambulances including a number of "bus-type" with special provision for sitting patients have been brought into service during the year; many have been fitted with radio equipment which has added greatly to operational efficiency.

The training of personnel in First Aid carried out in conjunction with the St. John Ambulance Brigade is showing very good progress towards the 100% standard which will take a further twelve months to achieve. In the meantime 78% of the Driver/Attendants have passed the recognised examination qualifying them for a First Aid Certificate which has to be renewed by examination every eighteen months.

Data for the Service during the year ended 31st December, 1949 is as follows:—

Patients conveyed by vehicles operated direct by County Council	...	...	...	199,539
Patients conveyed by vehicles operated by Agency Services	...	...	...	33,965
				<u>233,504</u>
Mileage run by County Operated Vehicles	...	...	...	2,032,021
Mileage run by Agency Services	...	...	...	438,417
				<u>2,470,438</u>

Analysis of Calls made on County Depots.

Accident	...	...	...	3,030
Urgent	...	...	...	8,937
Maternity	...	...	...	6,492
Infectious	...	...	...	1,775
Mental	...	...	...	1,718
Out-patients	...	...	...	153,326
Other patients	...	...	...	46,213

Analysis of Types of Cases Conveyed.

Child	...	...	...	22,525
Baby	...	...	...	3,822
Stretcher Case	...	...	...	42,172
Sitting Case	...	...	...	157,367
Ambulance Users	...	...	...	188,329
Car/Shoot Brake	...	...	...	10,115
Relative conveyed with patient	...	...	...	57,219
False Calls	...	...	...	2,138
Patients conveyed by train	...	...	...	77

Agencies.

Cases	...	...	...	33,965
Mileage	...	...	...	438,417

PART IX

MENTAL HEALTH

Administration

The local health authority has appointed a Mental Health Sub-Committee which meets monthly, consisting of 24 members of the Health Committee, to which is referred the detailed administration of the mental health services of the County Council.

The mental health section of the County Health Department is under the immediate day-to-day supervision of a mental deficiency psychiatrist, Dr. H. J. O'Loughlin, whose services we use in accordance with an agreement between the County Council and the Leeds Regional Hospital Board. In virtue of a similar agreement, a psychiatrist in lunacy, the counterpart of Dr. O'Loughlin, is soon to be appointed. There are 2 petitioning officers in mental deficiency; 24 duly authorised officers under the Lunacy and Mental Treatment Acts (who also perform welfare duties under the National Assistance Act), one of whom possesses the Diploma of Public Administration; three hold the certificate of the former Poor Law Examinations Board in the duties of a Relieving Officer and one also holds the Clerical Assistants Certificate of the Board; 10 Social Workers (4 vacancies), 2 of whom hold Social Science Diplomas and most of the others have had considerable experience in Social Welfare; 1 Occupation Centre Supervisor, 1 Assistant Supervisor and 2 Nursery Assistants and 2 home teachers of mentally defective persons. The Consultant Psychiatrist in mental deficiency is an officer of the Regional Hospital Board and the Authority's Mental Health Social Workers undertake on behalf of the Hospital Management Committees, the supervision of mentally defective persons on licence from Institutions; provide reports on the home circumstances of patients on the reconsideration of cases and in connection with applications for licence, holiday leave, etc. The Mental Health Social Workers also provide, on request, background information relating to patients admitted to Mental Hospitals. All but one of the Mental Health Social Workers have attended Extra-mural courses of study at Universities, as also have six of the Duly Authorised Officers, and monthly discussion meetings are held.

Under the guidance of the Divisional Medical Officers, Mental Health Social Workers are undertaking an increasing amount of mental care and after-care under Section 28 of the National Health Service Act, 1946, but this work must of necessity be restricted owing to the staff being under strength and there being no Psychiatric Social Workers. The Duly Authorised Officers have also, in conjunction with the Divisional Medical Officer, undertaken a limited amount of care and after-care.

The Lunacy and Mental Treatment Acts, 1890-1930

Action taken during 1949 under the above Acts by the Duly Authorised Officers was as follows

Patients admitted to Mental Hospitals:—

Under Section 16 of the Lunacy Act 1890	...	...	...	...	...	543	
Under Section 20	...	...	...	...	...	80	
Under Section 21	...	...	...	...	...	30	653
Under Section 5 of the Mental Treatment Act 1930	...	...	...	...	...	19	
Patients assisted under Section 1 of the Mental Treatment Act 1930	...	...	...	...	...	157	176
							829

No action was taken under the Lunacy and Mental Treatment Acts in respect of 147 cases referred to the Duly Authorised Officers, many of these being old people who were either admitted to chronic sick accommodation or satisfactory arrangements were made for their care in the community. Others of these cases included women who were mentally overwrought and hysterical following domestic quarrels (these were taken home and their own Doctors informed and requested to visit), European Volunteer Workers taken to a Holding Camp for interview with, and treatment by, a doctor of their own nationality, etc.

Most of the Duly Authorised Officers comment on the distressing number of elderly and old senile patients, who present a difficult problem. There appears to be an increasing tendency for relatives and medical practitioners to request the admission of many of these old people to mental hospitals when chronic sick accommodation is not available. Owing to the acute shortage of accommodation both in chronic sick hospitals and in mental hospitals, the suggestion is made by one Duly Authorised Officer that special accommodation should be provided for these old people, something in the nature of a half-way house, where they could be kept under observation and a final decision made whether they should be admitted to chronic sick hospitals or to mental hospitals.

In two instances, the Duly Authorised Officer has office accommodation in the Divisional Public Health Office and both comment on the advantage of this arrangement to the Divisional Medical Officer, Social Workers and themselves and on the ease of consultations for the benefit of the patients concerned. One of the Divisional Medical Officer's comments on this arrangement is as follows:— "I have also in my office the Assistant Welfare Officer and Duly Authorised Officer. He is one of the old Relieving Officers whose knowledge of mental illness and the disposal of such cases is very wide. I have had none of the heart burnings as between myself and the District Welfare Officer and I must put on record the relationship existing between the Welfare Department and this Divisional Office is most harmonious. It is amazing the comfort and help that the Assistant Welfare Officer can be in dealing with the problem of the aged."

There is still considerable difficulty in obtaining admission to Mental Hospitals.

Mental Deficiency Acts 1913-38

316 persons were reported during 1949 to the Mental Health Authority as being mentally defective persons. Of these 204 were reported under Section 57 of the Education Act, 1944, the remainder (112) being ascertained from other sources, such as the police, probation officers, N.S.P.C.C., family doctors, mental health social workers and parents.

By the end of the year these 316 reported cases had been disposed of as follows:— Admitted to Institutions 28; Admitted to "Places of Safety" 4; Placed under Statutory Supervision 201; Died or removed from the area 6; Action not completed by the end of the year 28; Found not "subject to be dealt with" 49.

On the 31st December 1949 the ascertainment of mentally defective persons in the Riding was as follows:— (a) Patients in Institutions for defectives or on licence therefrom 1,383; (b) In "Places of Safety" 6; (c) Under Statutory Supervision 1,647; (d) Under Guardianship 206; (e) Not "subject to be dealt with" but under Voluntary Supervision, etc. 216; (f) Persons ascertained but action not yet completed 64; total 3,522.

Orders were made during the year sending 133 mentally defective persons to Institutions (58 during 1948). The Orders were made as follows:— 109 by Petition; 13 under Section 8; 1 under Section 9 and 10 by Varying Orders from Guardianship. Of these 133 patients, 103 were admitted to Institutions in the area of the Leeds Regional Hospital Board; 28 to Institutions in the Sheffield Regional Board's Area and 1 each to Institutions in the Manchester and Bristol areas. At the end of the year there were 142 patients urgently requiring Institutional care; there were many more patients in their homes for whom a period of training in an Institution would be a great advantage and also many mentally defective persons in Mental Hospitals and in accommodation provided under Part III of the National Assistance Act 1948, Children's Homes, etc. for whom accommodation in Institutions for defectives was required. There were 262 patients under guardianship on the 1st January, 1949, and during the year 3 patients were placed under guardianship. The Board of Control discharged 29 Orders for Detention under guardianship; 14 Orders lapsed by operation of law; 10 patients were transferred from guardianship to institutions and 2 patients died during the year leaving 210 under guardianship on the 31st December, 1949, of whom 4 were other authorities' cases, leaving a total of 206 West Riding cases under Guardianship. The National Assistance Board accepted during the year financial responsibility for 120 patients under guardianship and this accounts for the unduly large number of discharges and lapse of orders, but the Board of Control are not being asked to discharge all guardianship orders where the National Assistance Board have accepted financial responsibility.

The duties of the Mental Health Social Workers are wide and varied being active assistance to help the patients to cope with life's problems. This is illustrated by the following report by one of the Divisional Medical Officers:— "The Mental Health Social Worker has performed her duties satisfactorily under conditions often difficult and uncongenial; the duties have been varied and have consisted of anything from persuading a feeble-minded woman to wear her new dentures to answering enquiries about Income Tax; the purchase of a layette for a new baby and making appointments for patients with dentists and opticians. Where necessary contacts have been made with the Employment Exchange and Local National Assistance Board in connection with financial assistance and clothing. The W.V.S. have been very helpful in providing clothing in necessitous cases and on two occasions it was necessary to call on the assistance of the N.S.P.C.C."

The following is an extract from the Annual Report of another Divisional Medical Officer:— "I am fortunate in connection with the Mental Health Service as I have a most efficient Mental Health Social Worker who never fails to enter into long discussions with me about all aspects of the service. I have also valuable help in certain directions other than mental health from her. There are some mental defectives in the Division who ought to be institutionalised and who are still living under sad home conditions. Is it any use to cry for more accommodation for these cases?"

173 of the patients under Statutory Supervision or Guardianship were receiving training at the end of the year; 70 at Day Training Centres and 103 in their own homes. There is an urgent need for additional Occupation Centres and Home Teachers. The Divisional Medical Officer for the Castleford and Normanton Division has reported as follows on the Occupation Centre in Castleford, which was opened on the 3rd March, 1949:— "Mrs. Dawson, the Supervisor, with the assistance of Mrs. Fox, commenced teaching a class of 14 children. To this staff was subsequently added a third who, however, left to do other work after less than 6 months. In May, further enrolments brought the number of pupils up to 29 and by the end of the year, they totalled 36. In November after two more appointments were made, thus making a total strength of 4 on the staff, the school was divided into three classes to cater for the needs of (1) lower (2) medium and (3) higher grade children. One happy and much appreciated feature of the Occupation Centre has been the regular monthly Mothers' Day whereby the parents can come along and see the progress their children are making. The children attending the Centre are drawn primarily from Divisions 11 and 16 but also from as far afield as Sherburn-in-Elmet etc. and three sitting cars are employed for their transport. The general work carried out at the centre comprises a curriculum of personal hygiene, table manners and politeness, physical training and safety first, speech and sense training linked with obedience, music and handicraft, with some domestic science training. It will be seen that this curriculum caters for a large variety of needs, ranging from the lowest to the highest grades, comprising the school. The Occupation Centre appears to be fulfilling a definite need, and my visits of inspection have shown that definite though varying degrees of positive progress have been attained by these children. It should prove to be the answer to a big social problem and it is obvious that parents realise and appreciate the value of proper care and training for their unfortunate offspring."

Supervision of Cases Reported under Section 57(5) of the Education Act, 1944

During the year 119 children, previously ascertained under Section 34 of the Education Act, 1944 as handicapped pupils in the educationally sub-normal category, were examined in their last term at school. In 63 cases reports were issued to the Local Health Authority under Section 57(5) of the Education Act, to the effect that the children were in need of supervision after leaving school. The remaining 56 children were not regarded as requiring supervision on account of mental deficiency and, although during their school life they had been regarded as handicapped pupils, they left school like any child of average intelligence and, as such, the School Health Service was no longer statutorily responsible for their future welfare. It is important that these children should be brought within the Authority's arrangements for care and after-care under Section 28 of the National Health Service Act, as the change over from school to employment is a period of major re-adjustment in the life of the child. The difficulties encountered are usually satisfactorily met by the child of normal intelligence but it is a period of great trial to the educationally sub-normal which calls for wise guidance on the part of everyone interested in the child's future welfare. Much valuable assistance can be, and is being, given by the Youth Employment Service, in studying the child's aptitudes and obtaining placement in suitable employment, but the task of the Youth Employment Officers will be greatly eased if periodical visits to the child's home are continued by officers of the health department at least until the child attains 18 years of age. This co-operation with the Youth Employment Service will ensure that the child's medical needs are considered along with other factors in those cases where the type of employment first advised has not proved to be the correct one for the child's mental outlook.

The success of this follow-up work under Section 28 of the Act will largely depend upon the degree of co-operation of the parents. That there is a need for some form of follow-up work is evident from a perusal of the case files of those educationally sub-normal children who are not the subject of a report under Section 57(5) of the Education Act. In 39 of the 56 cases not reported, the intelligence quotient was below 75; in 4 cases it was less than 60. Many of these children have learned little in matters of reading and writing but possess certain practical capabilities which should be fostered and directed into suitable channels on leaving school. The task can be made easier where the home conditions of the child are satisfactory and the attitude of the parents is one of interest and co-operation in all matters affecting the child's future welfare.

The value of the work is shown in the results of the special arrangements made during the year for the care of the epileptic child, an account of which is given in the Section of the Report dealing with the Health of the School Child. I would like to see an extension of these arrangements to eventually embrace handicapped pupils in all categories, as an important step in the future of social medicine.

PART X

ENVIRONMENTAL HYGIENE

Atmospheric Pollution

The results of the examination of the deposit gauges which are maintained at the cost of the County Council were as follows for the year 1949 :—

Situation of Deposit Gauge*	Average monthly rainfall (inches)	Mean monthly deposits recorded (in tons per sq. mile)		
		Insoluble	Soluble	Total Solids
Keighley M.B. :—				
Abattoir	2·31	4·46	8·56	13·02
Oldfield	2·48	2·87	9·16	12·03
Low Bridge	2·01	7·18	8·34	15·52
Library	2·44	10·76	9·57	20·33
Colne Valley U.D.	3·40	6·55	10·50	17·05
Horsforth U.D.	2·26	7·29	7·75	15·04
Otley U.D.	2·38	6·47	9·12	15·59
Skipton U.D.	2·95	5·44	10·56	16·00

* The gauge at the Keighley Abattoir, which was transferred from Morton Cemetery on 1st January, 1949, is $\frac{3}{4}$ mile N.E. of the town centre in a very open situation on the northern outskirts of the built-up area. The gauge at Oldfield is on an exposed site in the path of prevailing rain bearing winds, in the grounds of the Keighley Corporation waterworks filter beds. That at Low Bridge is on the flat roof of a textile mill in a built-up area on the north east side of a dense industrial area, whilst that at the Keighley Public Library is in a built-up area in the centre of the town with no trees, etc., near. The Colne Valley U.D. gauge is in Marsden Park in a residential and manufacturing area, seven miles south of Huddersfield. There are eight major factory chimneys within one mile of the gauge. The Horsforth U.D. gauge is situated at the rear of 78, Broadgate Walk, Horsforth, in the centre of the built-up area. The surrounding district is residential. The Otley U.D. Gauge is in nursery gardens, 600 yards south west of the centre of the town. The district is a manufacturing one. The Skipton U.D. gauge is at the rear of the Town Hall in a residential and manufacturing district.

The Department of Scientific and Industrial Research have for some years been making an investigation into the nature of atmospheric pollution and the best ways of measuring it, in which Local Authorities and other Bodies have been invited to co-operate, chiefly by the setting up and maintenance of deposit gauges, and other instruments of a standard pattern, and arranging for the contents thereof to be analysed at monthly intervals. As very few West Riding County District Councils were co-operating in the scheme, the County Council in January, 1936, agreed to bear the cost of analyses, that is the major part of the cost of maintaining deposit gauges, placed in approved situations in the Administrative County. The response by the Councils of County Districts was very poor and at the end of 1939 the only gauges operating under the arrangement were situate at Marsden (Colne Valley U.D.), Keighley, Otley and Skipton. But for the outbreak of the war, there was a probability that the County Council would have considered other means to bring about an increase in the number of instruments in the County. In January, 1949, the County Council approved of a scheme for the provision of deposit gauges, lead peroxide instruments and smoke filter equipment in each Public Health Divisional Area. When the scheme is fully in operation there will be 40 to 45 deposit gauges, 45 to 50 lead peroxide instruments for ascertaining the amount of sulphur dioxide in the atmosphere and about 30 smoke filters for the measurement of smoke or suspended matter in the atmosphere. It was hoped that some or all of the new instruments would be in operation in 1949, but delivery of equipment was not made soon enough.

In co-operation with Sanitary Inspectors of County Districts 25 observations of works chimneys, as to the emission of smoke, were made. In cases of excessive smoke being found, visits were made to the works and efforts made to secure abatement of the nuisances. A series of investigations was made in connection with an alleged nuisance from sulphur and other fumes at a school. Exposure plates were deposited in various positions at the school and later collected and submitted to the County Analyst for examination for the presence of sulphur dioxide, etc.

Four meetings of the West Riding of Yorkshire Regional Smoke Abatement Committee were attended.

Milk

Milk (Special Designations) Regulations—As in previous years the work devolving upon the County Sanitary Inspectors in connection with the above Regulations occupied a considerable amount of their time during the year up to the 30th September, after which date the duties in connection with raw milk production were transferred from Local Authorities to the Ministry of Agriculture and Fisheries. /

At the time of the change over there were 755 licences for Tuberculin Tested Milk and 753 for Accredited Milk.

The County Council may justly be proud of the extensive improvements to some hundreds of farm premises, brought about by way of improvements to existing buildings and erection of new buildings for use in connection with the production of designated milk.

During the nine months of the year during which the County Council was responsible for supervising designated milk farms, 1938 visits were made in connection with applications for licences and to ascertain the conditions regarding cleanliness of the premises, utensils, equipment, etc., and in general to see that the conditions attached to the licences were being complied with.

Samples of designated milks were obtained as follows:—

			Number.			Satisfactory.		Unsatisfactory.
"Tuberculin Tested"	...	...	424	...	...	365	...	59
"Accredited"	...	...	589	...	...	526	...	63

The following table shows the numbers of designated milk licensees from 1941 to the 30th September, 1949:—

Year.			"Tuberculin Tested" Milk.			"Accredited" Milk.
1941.	...	...	65	...	...	863
1942.	...	...	61	...	...	888
1943.	...	...	101	...	...	908
1944.	...	...	158	...	...	961
1945.	...	...	213	...	...	962
1946.	...	...	330	...	...	926
1947.	...	...	421	...	...	874
1948.	...	...	585	...	...	792
1949.	...	...	755	...	...	753

The great increase in the number of "Tuberculin Tested" licensees, together with a large number of "Attested" herds under the Ministry of Agriculture's Attested Herds Scheme, tends to show that milk of an increasingly high standard is being produced in the County Area.

The Supply of Milk to School Children—The Provision of Milk and Meals Regulations dated 6th June, 1945, state:—

"1. The source and quality of the milk supplied for drinking shall be approved by the Medical Officer of Health for the County or County Borough concerned after consultation with the Medical Officer of Health for any County District concerned, and, if the School Medical Officer is a person other than either of the two officers first-mentioned, with that officer.

2. If milk which satisfies the requirements (1) of this Regulation is not available, the Minister may approve the substitution therefor of an equivalent quantity of full-cream dried milk suitably prepared for drinking, and if he so approves the Authority shall make that substitution."

Under the existing scheme milk is supplied to school children in one-third pint bottles. The only exceptions to this arrangement are the more isolated schools, which, of necessity, must be supplied with liquid milk in bulk or dried milk.

The amount of milk supplied is shown in the following table:—

Total bottles supplied	...	33,979,357	Average number of bottles per day	...	169,290
Total number of schools supplied with milk (a) in bottles.	...	...	996 (Departments 1205).		
			(b) in bulk	...	9

559 samples were obtained during the year and of these 467 were satisfactory and 92 unsatisfactory.

Milk Samples under Regulation 55G—During the period 1st January to 30th September, 1949, samples of "Heat-treated" milk were obtained on behalf of the Ministry of Food as follows:—

Phosphatase test.				Methylene Blue test.			
Number			Not				Not
Obtained.	Satisfactory.	Unsatisfactory.	examined.	Satisfactory.	Unsatisfactory.		examined.
483	461	21	1	440	19		24

Unsatisfactory reports were immediately notified to the Ministry.

Sampling of Milk from Hospital Farms—At the request of the Ministry of Health, samples were obtained from the following hospital farms:— Menston, Middleton Sanatorium, Middlewood, Scalebor Park, Stanley Royd, Storthes Hall, Stansfield View and Wheathead.

The results of the examination of the samples in the various tests were as follows:—

			No.		Satisfactory.		Unsatisfactory.		No result.
Methylene blue test	...	...	100	...	76	...	21	...	3
B. Coli.	...	...	5	...	4	...	1	...	—
Tubercle.	...	...	24	...	24	...	—	...	—
Brucella Abortus.	...	...	19	...	14	...	5	...	—

Monthly returns were furnished to the Ministry.

Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949—These Regulations came into force on the 1st October, 1949, and all licences authorising the use of a special designation in accordance with those Regulations in relation to milk pasteurised or sterilised on the premises of the applicant are now granted by Food and Drugs Authorities, within the meaning of Section 64 of the Food and Drugs Act, 1938. The County Council, therefore, is the licensing authority for the Administrative County Area with the exception of four County Districts where the District Councils are the Food and Drugs Authority.

At the end of the year the following pasteurising licences were in force:—

- (1) C.W.S. Ltd. Premises at Maxwell Street, Morley.
- (2) Skipton District Dairy Farmers Ltd. Broughton Road, Skipton.
- (3) A. Wild, Prospect Farm, Grotton, Nr. Oldham.
- (4) H. A. Button, York Road, Wetherby.
- (5) H. Paley and Son, Brandon Nook Farm, Shadwell, Nr. Leeds.
- (6) H. J. W. Scarr, Prospect House Farm, Bradley, Keighley.
- (7) West Marton Dairies Ltd., The Dairy, West Marton, Skipton.
- (8) J. E. and E. Oates, Thorne Dairies, Thorne.
- (9) J. Marver and Son, Skellow, Nr. Doncaster.
- (10) Whittaker's Wholesale Dairies, Adwick-le-street, Nr. Doncaster.
- (11) Lawrence Bros., Bramhope, Nr. Leeds.
- (12) Pontefract Industrial Co-operative Society Ltd.
- (13) Dobsons Dairies Ltd., Barnoldswick.
- (14) Goole Co-operative Society Ltd.
- (15) E. O'Shaughnessy, Normanton.
- (16) L. W. Roberts, Eastfield Dairies, Normanton.
- (17) Kirkby Malzeard Dairy Co. Ltd., Nr. Ripon.
- (18) Stocksbridge Co-operative Society.
- (19) Busfield and Hargreaves, Rawson Dairy, Farsley, Nr. Leeds.
- (20) A. Yates, Hightown, Liversedge, Cleckheaton.
- (21) Doncaster Co-operative Society Ltd.
- (22) Wholesale Dairies (Rotherham) Ltd., Rawmarsh.
- (23) G. Millington, Denison's Yard, Yeadon.
- (24) Windhill Co-operative Society Ltd., Shipley.
- (25) Knowles Bros., Garforth, Nr. Leeds.
- (26) West Riding Dairy Farmers (Wholesale) Ltd., Sowerby Bridge.
- (27) Miss B. J. Mudd, Aldborough, Boroughbridge.
- (28) Wharfedale Creamery Co. Ltd., Ilkley.
- (29) P. Salmon, Littlethorpe, Ripon.

These establishments must be regularly supervised by the County Sanitary Inspectors, who check the methods of production, see that the recording instruments and other equipment are in order, inspect the premises in general and at times obtain washed bottles for the purpose of bacteriological examination. During the three months of supervision, 84 visits were made and appropriate action taken where infringements of the Regulations were found.

The following conditions apply to milk in relation to which the special designation "Pasteurised" is used:—

The milk shall be pasteurised, i.e.:—

- (a) retained at a temperature of not less than 145°F. and not more than 150°F. for at least thirty minutes and be immediately cooled to a temperature of not more than 50°F., or
- (b) retained at a temperature of not less than 161°F. for at least fifteen seconds and be immediately cooled to a temperature of not more than 50°F., or
- (c) retained at such temperature for such period as may be specified by the licensing authority with the approval of the Minister.

Samples of pasteurised milks are subjected to the phosphatase and methylene blue tests. The former test is to prove the efficiency of the treatment as to whether or not the milk has been properly pasteurised, or whether any raw milk has been added after treatment. The methylene blue test shows the keeping quality of the milk.

From the 1st October to the 31st December, samples were obtained as follows:—

Phosphatase test.				Methylene blue test.		
Total.	Satisfactory.	Unsatisfactory.	No result.	Satisfactory.	Unsatisfactory.	No result.
217	213	1	3	208	5	4

No licences are yet in force in the County Administrative Area regarding sterilised milk.

Food and Drugs Act, 1938

All County Inspectors of Weights and Measures are appointed Sampling Officers for the purpose of the above Act, and the work of sampling is carried out under the control of the Chief Inspector of Weights and Measures, Mr. J. W. Hopkinson, who has compiled the following report.

During the year 1st January to 31st December, 1949, 4,141 samples were procured and submitted to the Public Analyst who certified 3,997 samples as genuine and 144 as adulterated.

A brief summary and classification of the samples is given hereunder :—

Milk	3,229
Milk Products	17
Ice Cream	129
Meat Products	87
Soup and Vegetable Products	14
Sauces and Condiments	135
Beverages	93
Fruits, Preserves and Sugar	115
Oil and Fat Products	37
Cereals and Confectionery	133
Miscellaneous Products	47
Drugs	105
	<u>4,141</u>

Of the 144 alleged adulterated samples 111 were in respect of milk which was low in the fat content or milk to which water had been added. 22 prosecutions were taken and 60 letters of warning were sent to milk retailers and dealers by the Clerk of the County Council. Of reports submitted to the Ministry of Food four prosecutions ensued for deficiencies in the meat content of sausage.

Attention was given by your sampling officers to the sale of Ice Cream in accordance with the Ministry of Food Circular 3/49 and in this respect 129 samples were forwarded to the Public Analyst. It was generally found that the standard in this County was much higher than the Ministry had suggested as a minimum amount of fat required to be present in Ice Cream.

Practically all the sampling of articles other than milk set out in the above summary has been carried out at the time Inspectors have visited shops on Weights and Measures Inspection. In a few instances the samples were taken arising from complaints.

The results of prosecutions during the year are tabulated below.

RESULTS OF PROSECUTIONS

Trader	Nature of Offence alleged	No. of Summonses	Result	Penalty
Milk Vendor	Milk contained 5.17% added water	1	Convicted	Fined £3 2. 0.
Milk Vendor	Milk contained 7.5% added water	1	Convicted	Fined £5 0. 0.
Milk Vendor	Milk contained 7.4% added water	2	Convicted	Fined £2 2. 0.
	Milk contained 6.1% added water			
Milk Vendor	Milk contained 6.8% added water	1	Dismissed	Costs £3 11. 0.
Milk Vendor	Milk contained 14.9% added water	3	Convicted	Fined £7 11. 6.
	Milk contained 17.7% added water			
	Milk contained 10.5% added water			
Milk Vendor	Milk contained 17.6% added water	2	Convicted	Fined £4 1. 0.
	Milk contained 19.0% added water			
Milk Vendor	Milk contained 13.4% added water	1	Discharged	Costs 14/6.
Farmhand	Added water to milk.	1	Convicted	Fined £6 1. 0.
Milk Vendor	Milk contained 5.1% added water	1	Convicted	Fined £5 12. 6.
Milk Vendor	Milk contained 28.7% added water	1	Convicted	Fined £6 13. 6.
Milk Vendors	Milk contained 15.2% added water	4	Convicted	Fined £22 2. 0.
	Milk contained 22.3% added water			
Milk Vendor	Milk contained 7.2% added water	1	Convicted	Fined £5 1. 0.
Milk Vendor	Milk contained 9.8% added water	2	Convicted	Fined £3 1. 0.
	Milk contained 7.1% added water			
Milk Vendor	Milk contained 8.0% added water	1	Convicted	Fined £22 12. 6.
Milk Vendor	Milk 35.3% deficient in fat	1	Dismissed	Costs 4/-.
Milk Vendor	Milk 26.0% deficient in fat	1	Dismissed	Costs £2 6. 0.
Milk Vendor	Milk 34.0% deficient in fat	1	Convicted	Fined £4 12. 6.
Milk Vendor	Milk 18.0% deficient in fat	2	Convicted	Fined £20 0. 0.
	Milk 43.7% deficient in fat			
Milk Vendor	Milk 24.7% deficient in fat	1	Dismissed	—
Milk Vendor	Milk 38.0% deficient in fat	1	Discharged	Costs 14/6d.
Milk Vendor	Milk 26.0% deficient in fat	1	Discharged	Costs 14/6d.
Butcher	Potted Meat contained only 41% Meat	1	Convicted	Fined £4 12. 6.
Publican	Whisky contained 18% added water.	1	Convicted	Fined £5 0. 0.

A scheme is in operation whereby the County Council pays the fees of the Public Analyst for all samples of milk taken by Sampling Officers of West Riding County District Councils in accordance with regulations made under the scheme, and also conducts all legal proceedings and defrays all consequential legal expenses. The number of samples of milk submitted for analysis under the scheme in 1949 was 600 of which 21 were found to be adulterated.

Sanitary Circumstances

Housing—A decent home is a primary social need. Good housing conditions mean something more than an arrangement of bricks and mortar and are of fundamental importance to the nation's health. The standards of fitness for a satisfactory house recommended by the Central Housing Advisory Committee are as under :—

The dwelling should :

- (i) be in all respects dry ;
- (ii) be in a good state of repair ;
- (iii) have each room properly lighted and ventilated ;
- (iv) have an adequate supply of wholesome water laid on for all purposes inside the dwelling ;
- (v) be provided with efficient and adequate means of supplying hot water for domestic purposes ;
- (vi) have an internal or otherwise readily accessible water closet ;
- (vii) have a fixed bath preferably in a separate room ;
- (viii) be provided with a sink or sinks and with suitable arrangements for the disposal of waste water ;
- (ix) be provided with facilities for domestic washing including a copper, preferably in a separate room ;
- (x) have a proper drainage system ;
- (xi) be provided with adequate points for artificial lighting in each room ;
- (xii) be provided with adequate facilities for heating each habitable room ;
- (xiii) have satisfactory facilities for preparing and cooking food ;
- (xiv) have a well-ventilated larder or food store ;
- (xv) have proper provision for the storage of fuel ;
- (xvi) have a satisfactory surfaced path to outbuildings and convenient access from a street to the back door.

There were 357,634 dwelling houses in Municipal Boroughs and Urban Districts, and 117,521 in Rural Districts.

County District Councils have continued under difficulties their schemes for re-housing, the numbers of new houses provided during the year being as follows :—

	<i>Permanent Traditional.</i>	<i>Permanent Prefabricated.</i>	<i>Permanent Aluminium Bungalows.</i>	<i>Total.</i>
Municipal Boroughs	702	47	19	768
Urban Districts	2,476	605	21	3,102
Rural Districts	880	1,007	246	2,133
	4,058	1,659	286	6,003

The following were erected by Private Enterprise :—

	<i>Houses.</i>	<i>Flats.</i>	<i>Police Houses.</i>
Municipal Boroughs and Urban Districts	288	30	13
Rural Districts	248	—	—

The unsatisfactory conditions under which many families are living is evidenced by the number of letters received in the County Public Health Department, and by visits made to the Department by residents in the County Districts.

During the year, 270 letters and visits were dealt with by reference to the Medical Officers of the County Districts concerned, and in several instances, the County Sanitary Inspectors made visits to the homes of the complainants, along with officers of the County Districts. Many of the complaints received were in connection with overcrowding by reason of two or more families living in one house. Particular attention has invariably been given in cases where members of a family have been notified as suffering from tuberculosis and it is to be noted that most County Districts have some form of priority scheme in such cases, when allocating houses.

HOUSING (RURAL WORKERS) ACTS, 1926-1941. During the year, 306 visits and inspections were made to cottages for which grants have been given under the above Acts. Detailed reports were prepared and furnished by the County Medical Officer to the Clerk of the County Council, regarding tenancies, structural conditions, etc., and later, the owners of the properties were notified of any defective structural matters. This work is of an extensive nature and entailed visits by the County Sanitary Inspectors to properties in the following Rural Districts :— Selby, Tadcaster, Ripon and Pateley Bridge, Nidderdale, Bowland, Wetherby, Kiveton Park, Hepton, Doncaster, Wakefield, Hemsworth, Rotherham, Wharfedale, Settle, Penistone, Goole. Other properties are situated in the outlying districts of Todmorden and Bingley.

The numbers of back-to-back houses, unfit houses and houses not in all respects reasonably fit for human habitation are shown below :—

Total Number of Districts in County.	Number of districts for which particulars have been given.	Total Number of Dwelling Houses therein.	No. of Houses stated to be :—		
			Back-to-Back,	Unfit,	Not in all respects fit.
68 Boroughs and Urban Districts.	61 64 65	318,513 328,788 338,674	29,531	2,055	13,295
21 Rural Districts	21	117,521	988	3,957	9,524

HOUSING ACT, 1949. The main provisions of this Act are:—

A local authority may give assistance in respect of the provision of dwellings, by a person other than a local authority or county council, by means of the conversion of houses or other buildings or the improvement of dwellings by such a person, by way of making a grant in respect of expenses incurred for the purpose of the execution of the works of conversion or improvement, provided that prior application is made to the authority by the applicant. Applications must contain full particulars of the improvement works proposed to be carried out, together with plans and estimates.

Before approving an application a local authority must satisfy themselves that as regards dwellings to be provided by improvement works, the dwellings will provide satisfactory housing accommodation for a period of not less than thirty years from the completion of the works.

OVERCROWDING. Due to the lack of reliable up-to-date information and other records, only 37 of the Municipal Boroughs and Urban Districts have been able to furnish details regarding the number of overcrowded houses at the end of the year. From the information supplied, however, the number of overcrowded houses is 3,793. The number of families living in these houses was approximately 5,587, involving 22,853 persons.

42 County Districts reported that during the year a total of 992 new cases of overcrowding had occurred and 48 reported that a total of 1,398 cases of overcrowding had been relieved, involving 6,500 persons.

Of the 21 Rural Districts, 17 have reported a total of 1,668 overcrowded houses at the end of the year, the number of families dwelling therein being 3,184, involving 12,944 persons.

14 of the Rural Districts reported that during the year 338 new cases of overcrowding had occurred and 15 reported that 574 cases of overcrowding had been relieved, involving 2,487 persons.

It is evident that more new houses are required to abate the evils caused by overcrowding and to re-house those persons living in houses which would normally have been subjected to action under the Housing Acts, either by Clearance or Demolition Orders. Surveys in connection with housing matters were being made in several County Districts.

Water Supplies—The supplies to the Municipal Boroughs and Urban Districts may be regarded as generally good and in the Rural Districts reasonably satisfactory.

The approximate percentage of dwelling houses on public water supplies was 97 in Municipal Boroughs and Urban Districts and 89 in Rural Districts. The houses not on the public supply in Boroughs and Urban Districts are mainly in outlying parts. The majority of houses not on public supplies in Rural Districts are in isolated areas away from existing public supplies and for which new schemes of supply would be very costly.

Constant sampling of water supplies is undertaken by officials of the County Districts and in cases where pollution, etc., is reported, action is taken with a view to remedy; the number of samples taken in 1949 is shown below:—

	Chemical Examination.			Bacteriological Examination.		
	Number.	Satisfactory.	Unsatisfactory.	Number.	Satisfactory.	Unsatisfactory.
Municipal Boroughs and Urban Districts.	671	663 (98.8%)	8	2,360	2,114 (89.5%)	246
Rural Districts.	114	103 (90.3%)	11	677	512 (75.6%)	165

During the year 20 applications were submitted regarding new schemes of water supply, improvement of existing supplies, etc., under the Rural Water Supplies and Sewerage Act, 1944.

Many supplies in the County are known, or suspected to be, plumbo-solvent, and, in accordance with the normal practice the County Health Department arranged for samples of such supplies to be submitted for examination for the presence of lead, the samples being taken in pairs, one after the water had stood in the lead service pipe for 30 minutes, and the other after the water had stood in the pipe all night. 132 samples from 66 supplies were collected and examined. In the case of only one supply was lead found to be present in quantities considered to be injurious to health. The results generally showed a marked improvement in regard to the freedom from the presence of lead, indicating that measures to counteract plumbo-solvency were effectively applied.

Scavenging and Refuse Disposal—The duties in connection with the above work may be regarded as satisfactorily undertaken. The only exceptions made in the public scavenging arrangements are in connection with outlying premises in seven Urban Districts and certain premises in remote parishes, and outlying farms in seven Rural Districts. The tables below show the various methods in use for the disposal of the refuse collected:—

	100% Controlled Methods.	Non-Controlled Methods.	Part Controlled methods and by destruction and disposal to farmers.	Part Controlled methods along with non-controlled methods.	Controlled methods, separation and incineration.	Controlled methods and destruction.	Controlled methods and disposal to farmers.
Municipal Boroughs and Urban Districts. (68)	43	3	3	5	1	6	7

	100% Controlled Methods.	Non-Controlled Methods.	Part Controlled Methods and part non-controlled methods.	Mainly controlled methods and some disposal to farmers.	Part controlled methods and some disposal to farmers.
Rural Districts (21)	10	3	2	5	1

Drainage and Sewerage—The following table shows the number and percentage of houses not connected to sewers and the reason therefor:—

	No available sewers.	No reasons given.	Small Holdings, etc.	Houses below sewer levels.	Outlying farms.	Isolated houses.	Houses more than 100 feet from Sewers.	Total.
Municipal Boroughs and Urban Districts.	4,014	4,679	8	172	291	616	1,013	10,793 (approx. 3%).
Rural Districts.	5,917	2,413			3,306			11,636 (approx. 10%).

In 48 Boroughs and Urban Districts and 26 Rural Districts extensions were made to existing sewers in connection with new housing schemes, etc.; 8 applications were submitted regarding new schemes for sewerage and sewage disposal under the Rural Water Supplies and Sewerage Act, 1944.

Nuisance Inspections and Action—The figures below relate to inspections made by Sanitary Inspectors of County Districts.

	Number of inspections made.	Nuisances found in 1949.	Nuisances in hand at end of 1948.	Total needing abatement.	Abated during 1949.	Outstanding nuisances at end of 1949.	Informal notices served.	Stat. notices served.
Municipal Boroughs and Urban Districts.	89,892	33,450	7,520	40,970	32,366	8,604	22,216	2,658
Rural Districts.	9,376	5,222	1,109	6,331	5,206	1,125	4,022	525
Totals.	99,268	38,672	8,629	47,301	37,572	9,729	26,238	3,183

The average number of nuisances abated during the year in each of the Municipal Boroughs and Urban Districts was 408, and in each of the Rural Districts 248.

Rural Water Supplies and Sewerage Act, 1944—During the year applications were made as follows for grants in aid of schemes:—

Name of Authority.	Description of Scheme.	Date of Application.	Estimated cost of Scheme.	County Council's Observations to Ministry.	Consulting Engineer's Report.
Bowland R.D.C.	Water Supply—Grindleton.	5.7.49.	£6,250		
Doncaster and Tickhill Joint Water Board.	Water Supplies—Kirk Bramwith and part of Moss Parish.	28.8.49.	£13,000		5.12.49.
Doncaster R.D.C.	Sewerage—Braithwell.	21.10.49.	£3,500		12.12.49
Hemsworth R.D.C.	Sewerage—Ackworth, Badsworth and Thorpe Audlin.	14.12.49.	£64,000	Ministry Inquiry held on 29.7.50.	
Nidderdale R.D.C.	Sinking of borehole, erection of softening plant, water tower and laying mains.	—	£45,958	Ministry Approval 10.8.49.	
Ripponden U.D.C.	Water Supply—Lighthazles Area.	5.5.49	£5,000	15.11.49.	28.10.49.
Rotherham R.D.C.	Re-sewering—Thurcroft.	27.5.49.	£22,350		3.11.49.
ditto.	Re-roofing of Dalton reservoir.	17.2.49. (amended).	£1,739		
ditto.	Re-roofing of Wickersley reservoir.	17.2.49. (amended).	£3,816		
Sedbergh R.D.C.	Sewerage and sewage disposal—Dent Parish.	21.10.49.	£5,760		
Skipton R.D.C.	Water Supply to Calton Parish.	24.3.49.	£817	3.5.49.	29.3.49.
ditto.	Improvement of water supplies to Oughtershaw in the parish of Buckden.	6.1.49.	£977	3.5.49.	29.3.49.
ditto.	Water Supply—Draughton.	11.8.49.	£10,480		28.11.49.
ditto.	General Scheme for Sewerage and Sewage Disposal.	—	£238,269		14.2.49.
ditto.	Sewerage and Sewage Disposal—Lane Ends, Cowling. (Revised).	21.4.49. (Revised).	£4,610		4.11.49. 9.2.49.
ditto.	Water Supply—Supplementary to Sutton Parish.	13.4.49.	£5,986		28.11.49.
Tadcaster R.D.C.	Extension of Water Mains—Church Fenton.	30.6.49.	£185	9.9.49.	6.7.49.
Thorne R.D.C.	Water Supplies—Stainforth, Fishlake and Fosterhouses.	11.1.49.	£8,844		
ditto.	Water Supply—Moor-ends (Scheme A).	7.2.49.	£4,064	8.7.49.	6.7.49.
ditto.	Water Supplies. Bloom Hill Road, Moorends. (Scheme 8).	8.2.49.	£930	8.7.49.	6.7.49.
ditto.	Water Supply—Hatfield Woodhouse.	8.2.49.	£6,070	8.7.49.	6.7.49.
ditto.	Water Supply—Stainforth (South Bramwith).	8.2.49.	£3,280	8.7.49.	6.7.49.
ditto.	Water Supply—(Broadway Dunscroft).	8.2.49.	£2,080	8.7.49.	6.7.49.
ditto.	Water Supply—(Slay Pits).	8.2.49.	£1,040	8.7.49.	6.7.49.
Wetherby R.D.C.	Water Supply—Angram.	26.8.49.	£1,756/6/3		5.12.49.
ditto.	Sewerage and Sewage Disposal—Angram. (2nd Scheme).	30.3.49.	£3,877	9.9.49.	11.8.49.
ditto.	Sewage Disposal—Thorp Arch.	22.7.49.	£49,000		29.4.49. 24.11.49.
Wortley R.D.C.	Water Supply—Brightholmlee.	—	£861 (Revised).		14.8.49.

Ministry of Health Inquiries Attended by the County Sanitary Inspectors

Date.	Sanitary Authority.	Locality.	Purpose.	Amount.
11.1.49.	Wharfedale R.D.C.	Blubberhouses, Clifton-with-Norwood,	Water Supply.	£16,100.
10.2.49.	Bingley U.D.C.	Fewston, Dowley Gap and Harecroft.	Sewage Disposal.	£204,000 and £2,000.
10.5.49.	Kiveton Park R.D.C.	Firbeck, North and South Anston, Todwick, Dinnington, Salvin.	Water Supply.	£64,600.
19.5.49.	Brighouse M.B.	Brighouse.	Sewerage Works.	£215,430.
21.9.49.	Spenborough U.D.C.	Spenborough.	Sewerage and Sewage Disposal.	£20,160.
24.11.49	Doncaster R.D.C.	Conisbrough Parks.	do.	£4,175.
6.12.49.	Wetherby R.D.C.	Boston Spa, Bardsey, Bramham.	Works of Sewerage.	£49,000.

SUMMARY OF VISITS AND DUTIES CARRIED OUT BY THE COUNTY SANITARY INSPECTORS.

Visits in connection with Tuberculin Tested Milk (farm surveys, re-surveys, etc.).	692
Visits in connection with Accredited Milk (farm surveys, re-surveys, etc.).	233
Routine visits to designated milk farms	1,938
Visits to other farm premises	6
Visits to licensed pasteurising establishments (from 1.10.49.)	84
Investigations regarding school milk premises	36
" " dirty school milk bottles	1
" " sanatorium milk supplies	1
" " T.B. in a child—milk supply	1
" " suspected food poisoning by milk	2
" " milk, with the Ministry of Food	1
Housing (Rural Workers) Acts visits	306
Housing investigations	12
Water Supplies enquiries and samples	21
Ministry of Health Inquiries attended—Sewerage	5
Water Supplies	2
Investigations regarding Sanitary Circumstances in County Districts	2
Survey of closet accommodation at an Institution	1
Smoke nuisance enquiries and observations	27
Atmospheric pollution at a school, enquiries and sampling	11
Investigations in connection with the Department of Scientific and Industrial Research (Smoke Abatement)	5
Investigations and survey regarding burning spoil banks	1
Smoke Abatement Meetings attended	4
Investigations regarding firing of a refuse tip	2
" " nuisance from rats	1
" " pests at a Training College	1
School Sanitary Accommodation enquiries	9
Enquiries regarding infestation by mice at school canteens	20
School Swimming Baths visits and samples of water obtained	2
Clinic Sanitary Accommodation enquiries	1
Investigations regarding suspected food poisoning at schools	15
School nursery enquiries	1
Investigations regarding dish-washing arrangements etc. at school canteens	36
Enquiries regarding appointment of Sanitary Inspector in the County Districts	5
Meetings with Divisional Medical Officers, Sanitary Inspectors etc.	97
Meetings of the County Agricultural Executive Committee (Milk and Advisory Committee)	6

PART XI

OTHER PUBLIC HEALTH SERVICES

National Assistance Act, 1948

Registration and Inspection of Disabled and Old Persons' Homes

In conjunction with the County Welfare Officer inspections of the under-mentioned property were carried out during 1949:—

	Recommended for registration	Number of Residents	Type of Home (Part I, II or III)*
Methodist Home for the Aged, Glen Rosa, Grove Road, Ilkley.	Yes ...	16	... Part I
Conference Committee of Managing Trustees on Methodist Homes for the Aged, Berwick Grange, 5, Otley Road, Harrogate.	Yes ...	19	... Part I

* Part I —Homes for Old Persons.

„ II „ „ Disabled Persons.

„ III „ „ Old Persons and Disabled Persons.

Registration of Nursing Homes

(Public Health Act, 1936, Sections 187-195).

Four Homes were first registered during the year. The number of Homes on the register at the end of the year was 44 providing 79 beds for maternity cases and 281 for other cases. No applications for registration were refused.

Agencies for the supply of Nurses

The Nurses Acts 1943-45 provide that no person shall carry on, on any premises in the Administrative County, an agency for the supply of nurses, unless he is the holder of a licence from the County Council authorising him to do so on those premises. Licences are granted on conditions regulating the suitability of the premises and the conduct of the agency. Only two agencies are established in the Administrative County and both have been carried on satisfactorily during the year.

Medical Examination of County Staff

An appointment to a superannuable post is subject to the applicant providing a satisfactory medical certificate, completed on the prescribed form by his or her family doctor, and submitted to the County Medical Officer for approval. Any fee for this examination is payable by the person examined. Should the medical certificate prove inconclusive a specialist's opinion is obtained at the expense of the County Council and the findings are made available to the family doctor.

During the year, 1,973 medical certificates were submitted for approval and of these, 76 were not approved. In 34 cases, further enquiries were made from the medical practitioner completing the certificate, and 123 cases were referred for a specialist's opinion. In addition, 88 special medical examinations of staff were arranged at the request of employing departments.

Hospitals serving the Administrative County

One of the changes brought about by the National Health Service Act, 1946, was to transfer most hospitals to the newly constituted Regional Hospital Boards. Hospitals included maternity homes, sanatoria and tuberculosis dispensaries. Teaching hospitals and associated hospitals were not transferred to the Boards but remained under Boards of Governors. Thus, practically all the voluntary hospitals and the local authority hospitals and sanatoria came under one administration from the appointed day. The hospital service is administered by Local Management Committees as agents of the Hospital Board, and the various hospitals are grouped together, usually according to situation and not according to classification of purpose.

The Management Committees with the names of the hospitals in the groups serving the administrative county are shown below:—

Leeds Regional Hospital Board

Management Committee No. 2

York (A) and Tadcaster Group

<i>Hospital.</i>						<i>Situation.</i>				<i>Beds.</i>
York County Hospital	...	...	...	...	...	York	...	...	...	222
Deighton Grove Annexe	...	...	...	...	...	York	...	...	...	40
York City General Hospital	...	...	...	...	...	York	...	...	...	180
York Poppleton Gate House (male)	...	...	...	...	...	York	...	...	...	50
York Poppleton Hall House (female)	...	...	...	...	...	York	...	...	...	35
Lambert Memorial Hospital	...	...	...	...	...	Thirsk	...	...	...	21
Easingwold and District St. Monica's Cottage Hospital	...	...	...	...	...	Easingwold	...	...	...	8
Acomb Maternity Hospital (including West Bank House Nurses' Home)	...	...	...	...	...	York	...	...	...	44
Fairfield Sanatorium	...	...	...	...	...	York	...	...	...	65
York City Fever Hospital	...	...	...	...	...	York	...	...	...	86
York Smallpox Hospital	...	...	...	...	...	Huntington	...	...	...	22
York City Mental Hospital	...	...	...	...	...	Fulford	...	...	...	393
Bootham Park Registered Mental Hospital.	...	...	...	...	...	York	...	...	...	136
Naburn Emergency Hospital	...	...	...	...	...	Fulford	...	...	...	450
P.A.I. Beds—York	...	...	...	...	...	York	...	...	...	275
Hazlewood Maternity Home	...	...	...	...	...	Tadcaster	...	...	...	25

Management Committee No. 3

York (B) Group

North Riding Mental Hospital, Clifton	...	...	...	...	...	York	...	...	...	1,024
North Riding Mental Hospital, Clifton (Annexe East Ayton Lodge, Scarborough)	...	...	...	...	...	Scarborough	...	...	...	20
Claypenny Colony	...	...	...	...	...	Easingwold	...	...	...	340
Mid-Yorkshire Institution for Mental Defectives	...	...	...	...	...	Whixley	...	...	...	215

Management Committee No. 7

Goole, Howden and Selby Group

Bartholomew Hospital, Goole	...	...	...	...	...	Goole	...	...	...	37
Goole Maternity Hospital	...	...	...	...	...	Goole	...	...	...	10
Goole I.D. Hospital	...	...	...	...	...	Goole	...	...	...	28
Howden Isolation Hospital	...	...	...	...	...	Howden	...	...	...	20
Rawcliffe Hall	...	...	...	...	...	Goole	...	...	...	121
Goole P.A.I.	...	...	...	...	...	Goole	...	...	...	134
Selby and District War Memorial Hospital and Brooke Dispensary	...	...	...	...	...	Selby	...	...	...	31
Selby I.D. Hospital	...	...	...	...	...	Selby	...	...	...	17

Management Committee No. 8

Pontefract and Castleford Group

Pontefract General Infirmary	...	...	...	...	...	Pontefract	...	...	...	60
Hydes Hospital (part of Pontefract General Infirmary)	...	...	...	...	...	Pontefract	...	...	...	42
Castleford, Normanton and District Hospital	...	...	...	...	...	Castleford	...	...	...	40
Castleford U.D.C. Maternity Hospital	...	...	...	...	...	Castleford	...	...	...	12
Warde Aldam Cottage Hospital	...	...	...	...	...	South Elmsall	...	...	...	32
South Elmsall Maternity Home	...	...	...	...	...	South Elmsall	...	...	...	6
Brierley Isolation Hospital	...	...	...	...	...	Brierley, near Barnsley	...	...	...	67
Pontefract and Baghill Joint Isolation Hospital	...	...	...	...	...	Pontefract	...	...	...	36
Ackton Isolation Hospital (Castleford Joint Isolation Hospital)	...	...	...	...	...	Featherstone	...	...	...	66
Castleford and District Smallpox Hospital	...	...	...	...	...	Glasshoughton	...	...	...	26
P.A.I. Beds—Hemsworth	...	...	...	...	...	Hemsworth	...	...	...	300
P.A.I. Beds—Pontefract	...	...	...	...	...	Pontefract	...	...	...	180

Management Committee No. 9

Wakefield (A) Group

Clayton Hospital (and Dispensary)	...	...	...	...	...	Wakefield	...	...	...	200
County General Hospital	...	...	...	...	...	Wakefield	...	...	...	159
Walton Hall Maternity Hospital	...	...	...	...	...	Wakefield	...	...	...	24
Municipal Maternity Hospital	...	...	...	...	...	Wakefield	...	...	...	35
Oulton Hall—M.D.	...	...	...	...	...	Near Leeds	...	...	...	307
Cardigan Sanatorium	...	...	...	...	...	Carr Gate, near Wakefield	...	...	...	50
Wakefield Municipal Isolation Hospital	...	...	...	...	...	Wakefield	...	...	...	93
Carr Gate Isolation Hospital	...	...	...	...	...	Near Wakefield	...	...	...	64
Hatfield Hall—M.D.	...	...	...	...	...	Wakefield	...	...	...	54
Sandal Grange P.A.I.	...	...	...	...	...	Wakefield	...	...	...	33
Stoneville, 112, York Street	...	...	...	...	...	Wakefield	...	...	...	18

Management Committee No. 10
Wakefield (B) Group

<i>Hospital.</i>					<i>Situation.</i>			<i>Beds.</i>
Wakefield Mental Hospital	...	...	...	...	Wakefield	...	...	1,550
Pinderfields Emergency Hospital	...	...	...	...	Wakefield	...	...	900
Stapleton Park Estate	...	...	...	...	Near Pontefract	...	...	—

Management Committee No. 18
Menston Group

Menston West Riding Mental Hospital	...	...	...	...	Menston	...	...	1,880
Highroyds Emergency Hospital	...	...	...	...	Menston	...	...	140

Management Committee No. 19
Ilkley and Otley Group

The Coronation Hospital, Ilkley	...	...	...	...	Ilkley	...	...	25
The General Hospital, Otley	...	...	...	...	Otley	...	...	260
Wharfedale Hospital, Menston	...	...	...	...	Menston	...	...	92
The Convalescent Hospital, Ilkley	...	...	...	...	Ilkley	...	...	90
Scalebor Park, Burley-in-Wharfedale	...	...	...	...	Burley-in-Wharfedale	...	...	289

Management Committee No. 20
Middleton and Grassington Group

The Hospital, Middleton-in-Wharfedale	...	...	...	...	Ilkley	...	...	542
The Hospital, Grassington	...	...	...	...	Grassington	...	...	302

Management Committee No. 21
Leeds (A) Group

St. James's Hospital—North	...	...	...	...	Leeds	...	...	450
St. James's Hospital—South	...	...	...	...	Leeds	...	...	1,296
Leeds Public Dispensary and Hospital	...	...	...	...	Leeds	...	...	40
Cookridge Hospital	...	...	...	...	Cookridge	...	...	102
St. Mary's Hospital	...	...	...	...	Armley, Leeds	...	...	239
Leeds Jewish Herzl-Moser Hospital	...	...	...	...	Leeds	...	...	40

Management Committee No. 22
Leeds (B) Group

St. George's Hospital	...	...	...	...	Rothwell	...	...	309
Marguerite Hepton Memorial Orthopaedic Hospital	...	...	...	...	Thorpe Arch	...	...	90
Killingbeck Hospital and Sanatorium	...	...	...	...	Leeds	...	...	242
City of Leeds Sanatorium, Gateforth	...	...	...	...	Gateforth, near Selby	...	...	52
The Hollies Sanatorium	...	...	...	...	Leeds	...	...	40
Seacroft I.D. Hospital	...	...	...	...	Leeds	...	...	406
Rothwell I.D. Hospital	...	...	...	...	Rothwell	...	...	50
Garforth Cliff I.D. Hospital	...	...	...	...	Garforth	...	...	20
Sherburn-in-Elmet Smallpox Hospital	...	...	...	...	Sherburn-in-Elmet	...	...	38
Killingbeck Smallpox Hospital	...	...	...	...	Leeds	...	...	22
Meanwood Park Colony	...	...	...	...	Leeds	...	...	608
Three Crooked Acres	...	...	...	...	Kirkstall, Leeds	...	...	31
Arthington Hall Convalescent Home	...	...	...	...	Arthington	...	...	50

Management Committee No. 23
Harrogate and Ripon Group

Harrogate and District General Hospital	...	...	...	...	Harrogate	...	...	250
Ripon and District Hospital and Nursing and Maternity Institution	...	...	...	...	Ripon	...	...	41
Harrogate Royal Bath Hospital	...	...	...	...	Harrogate	...	...	78
Rawson Convalescent Home (Part of Harrogate R.B.H.)	...	...	...	...	Harrogate	...	...	60
Carlton Lodge Municipal Maternity Home	...	...	...	...	Harrogate	...	...	11
Yorkshire Home for Chronic and Incurable Diseases	...	...	...	...	Harrogate	...	...	70
Sunderland Royal Infirmary (Heatherdene Convalescent Home)	...	...	...	...	Harrogate	...	...	40
Durham County Hospital Convalescent Home	...	...	...	...	Harrogate	...	...	22
Mowbray Grange Sanatorium	...	...	...	...	Bedale	...	...	30
Thornton Lodge Children's Sanatorium	...	...	...	...	Aysgarth	...	...	40
Scotton Banks Sanatorium	...	...	...	...	Knaresborough	...	...	410
Ripon Joint I.D. Hospital	...	...	...	...	Ripon	...	...	38
Masham I.D. Hospital	...	...	...	...	Masham	...	...	20
Harrogate Joint I.D. Hospital	...	...	...	...	Knaresborough	...	...	54
P.A.I. Beds—Knaresborough	...	...	...	...	Knaresborough	...	...	125
P.A.I. Beds—Wetherby	...	...	...	...	Wetherby	...	...	72

Management Committee No. 11
Dewsbury, Batley and Mirfield Group

<i>Hospital.</i>					<i>Situation.</i>				<i>Beds.</i>
Batley and District General Hospital	...	...	...	...	Batley	...	...	...	102
Dewsbury and District General Infirmary	...	...	...	...	Dewsbury	...	...	...	100
Ravensleigh Convalescent Annexe	...	...	...	...	Dewsbury	...	...	...	18
Mirfield Memorial Hospital	...	...	...	...	Mirfield	...	...	...	20
Staincliffe County Hospital	...	...	...	...	Dewsbury	...	...	...	286
Batley Maternity Home	...	...	...	...	Batley	...	...	...	10
Morley Hall Maternity Home	...	...	...	...	Morley	...	...	...	11
Moorlands Hall Maternity Home	...	...	...	...	Dewsbury	...	...	...	27
Whitley Grange Sanatorium	...	...	...	...	Dewsbury	...	...	...	30
Bruntcliffe Isolation Hospital	...	...	...	...	Morley	...	...	...	24
Grange Smallpox Hospital	...	...	...	...	Morley	...	...	...	36
Liversedge and Mirfield Isolation Hospital (at present being used as a fifteen-bedded Maternity Hospital)	...	...	...	...	Crossfield, Mirfield	...	...	...	41
North Bierley Joint I.D. Hospital	...	...	...	...	Cleckheaton	...	...	...	52
Oakwell Joint Isolation Hospital	...	...	...	...	Birstall	...	...	...	80
Oakwell Smallpox Hospital	...	...	...	...	Birstall	...	...	...	16
Mitchell Laithes I.D. Hospital	...	...	...	...	Dewsbury	...	...	...	102
Mitchell Laithes Smallpox Hospital (Site and House only)	...	...	...	...	Dewsbury	...	...	...	—
Liversedge and Mirfield Smallpox Hospital (Site)	...	...	...	...	Dewsbury	...	...	...	—

Management Committee No. 12
Storthes Hall Group

Storthes Hall Mental Hospital	...	...	...	...	Kirkburton	...	...	...	2,335
The Mansion (M.D.)	...	...	...	...	Kirkburton	...	...	...	60

Management Committee No. 13
Huddersfield Group

Huddersfield Royal Infirmary	...	...	...	...	Huddersfield	...	...	...	302
Huddersfield Greenlea Branch	...	...	...	...	Lindley, Huddersfield	...	...	...	19
Holme Valley Memorial Hospital	...	...	...	...	Holmfirth	...	...	...	39
St. Luke's Hospital (P.A.I.)	...	...	...	...	Crosland Moor	...	...	...	272
Woodhouse Hall—Annexe to St. Luke's Hospital	...	...	...	...	Milnsbridge	...	...	...	40
Princess Royal Maternity Home	...	...	...	...	Huddersfield	...	...	...	57
Holywell House, Holywell Green	...	...	...	...	Elland	...	...	...	9
Deanhouse Emergency Hospital (P.A.I.)	...	...	...	...	Thongsbridge, Holmfirth	...	...	...	342
Bradley Wood Sanatorium	...	...	...	...	Huddersfield	...	...	...	75
Mill Hill Isolation Hospital	...	...	...	...	Huddersfield	...	...	...	176
Colne and Holme Isolation Hospital	...	...	...	...	Meltham	...	...	...	75
Hargreaves Convalescent Home	...	...	...	...	Greenfield, near Oldham (Part of Oldham Royal Infirmary)	...	...	...	28

Management Committee No. 14
Halifax Group

Royal Halifax Infirmary	...	...	...	...	Halifax	...	...	...	283
Warley House (attached to Royal Halifax Infirmary)	...	...	...	...	Halifax	...	...	...	—
Halifax General Hospital	...	...	...	...	Halifax	...	...	...	400
Halifax P.A.I.	...	...	...	...	Halifax	...	...	...	387
Todmorden County P.A.I.	...	...	...	...	Todmorden	...	...	...	145
The Shelf Sanatorium	...	...	...	...	Shelf, Halifax	...	...	...	62
Halifax Isolation Hospital	...	...	...	...	Halifax	...	...	...	96
Fielden Joint Isolation Hospital	...	...	...	...	Todmorden	...	...	...	56
Sourhall Smallpox Hospital	...	...	...	...	Todmorden	...	...	...	34

Management Committee No. 15
Bradford (A) Group

Bradford Royal Infirmary	...	...	...	...	Bradford	...	...	...	439
Bradford Regional Radium Institute	...	...	...	...	Bradford	...	...	...	56
Woodlands Convalescent Home and Hospital	...	...	...	...	Rawdon	...	...	...	96
The Municipal General (St. Luke's) Hospital	...	...	...	...	Bradford	...	...	...	969
									plus 111 cots
Bradford Children's Hospital	...	...	...	...	Bradford	...	...	...	104
Sir Titus Salt's Hospital	...	...	...	...	Shipley	...	...	...	24
Royal Eye and Ear Hospital	...	...	...	...	Bradford	...	...	...	102
St. Catherine's Home	...	...	...	...	Manningham, Bradford	...	...	...	46
Shipley and Bingley Joint Maternity Home	...	...	...	...	Shipley	...	...	...	19
Waddilove's Samaritan Hospital	...	...	...	...	Bradford	...	...	...	12

Management Committee No. 16**Bradford (B) Group**

<i>Hospital.</i>	<i>Situation.</i>	<i>Beds.</i>
Brierley Hall Sanatorium	Bradford	44
Heaton Royds Smallpox Hospital	Shipley	14
Calverley Moor Isolation Hospital	Thornbury	76
Bradford I.D. Hospital	Bradford	250
Bradford Smallpox Hospital, Thornton	Bradford	40
Stoney Ridge I.D. Hospital	Cottingley, near Bingley	30
Westwood M.D. Institution	Bradford	350
Lynfield Mount, Heights Lane, Allerton	Bradford	86
Northern View, Rodley Avenue, West Bowling	Bradford	90
Ashfield Institution (M.D.)	Bradford	20
Bowling Park Institution	Bradford	140
Clayton Institution	Bradford	294

Management Committee No. 17**Keighley, Skipton, Settle Group**

Keighley and District Victoria Hospital	Keighley	146
Skipton and District Hospital	Skipton	64
Bingley and District Hospital	Bingley	73
County Hospital, Fell Lane	Keighley	406
Barnoldswick Isolation Hospital	Barnoldswick	6
Morton Banks Isolation Hospital	Keighley	104
Sedbergh Isolation Hospital	Sedbergh	4
Harden Bridge Isolation Hospital	Austwick	18
		plus 4 cots
Skipton Isolation Hospital (now Maternity Home)	Skipton	30
Skipton—P.A.I. Beds	Skipton	200
Settle—P.A.I. Beds	Settle	133

Sheffield Regional Hospital Board**Sheffield No. 2 Hospital Management Committee**

Aston Hall Institution	Aston, near Sheffield	30
Girls' Hostel, Sheffield	Scot Road, Sheffield	14
Grange Institution	Kimberworth	—
Hollow Meadows Institution	Sheffield	58
Middlewood Hospital	„	1,747
Wales Court, Kiveton	„	50
Wharncliffe Emergency Hospital	„	615

Rotherham and Mexborough Hospital Management Committee

Brampton-en-le-Morthen Smallpox Hospital	Brampton	—
Hallamshire Maternity Home	Chapelton	22
Kimberworth Smallpox Hospital	Rotherham	12
Listerdale Maternity Home	Wickersley	20
Montagu Hospital	Mexborough	123
Oakwood Hall Sanatorium	Rotherham	100
Rosehill Infectious Diseases Hospital	Rawmarsh	22
Rotherham Hospital and Dispensary, with Annexe	Rotherham	200
Rotherham Municipal General Hospital	„	331
Rotherham Infectious Diseases Hospital	„	64
Sandygate Maternity Home	„	19
Swallownest Infectious Diseases Hospital	„	82
Wathwood Infectious Diseases Hospital	Wath-on-Deane	79
Rotherham Institution, Rotherham (Joint)		

Doncaster Hospital Management Committee

Conisbrough Infectious Diseases Hospital	Conisbrough	84
Crookhill Hall Sanatorium	„	42
Crookhill Smallpox Hospital	„	—
Doncaster Infectious Diseases Hospital and Sanatorium	Doncaster	112
Doncaster Smallpox Hospital		
Doncaster Royal Infirmary and Dispensary	„	330
Fullerton Hospital, Denaby Main		
Municipal Maternity Home, Hamilton Lodge	„	14
Springwell House Institution and Hamilton Annexe	„	195
St. Catherine's Institution	„	480

Barnsley Hospital Management Committee

<i>Hospital.</i>					<i>Situation.</i>				<i>Beds.</i>
Beckett Hospital and Dispensary ...	...	...	...	...	Barnsley	...	...	...	195
Kendray Infectious Diseases Hospital	...	...	...	...	„	...	...	...	112
Lundwood Smallpox Hospital	...	...	...	...	„	...	...	...	42
Municipal Maternity Home ...	...	...	...	...	„	...	...	...	10
Mount Vernon Sanatorium ...	...	...	...	...	„	...	...	...	53
Penistone Infectious Diseases Hospital	...	...	...	...	Penistone	...	...	...	22
St. Helen's Municipal General Hospital	...	...	...	...	Barnsley	...	...	...	240
Barnsley Institution ...	...	...	...	...	„	...	...	...	—

PART XII

STAFF

(December, 1949)

C. Fraser Brockington, M.A., M.D., B.Ch., D.P.H., M.R.C.S., L.R.C.P., Barrister-at-Law.
(County Medical Officer and School Medical Officer).

HEADQUARTERS

J. Wood-Wilson, F.D., M.D., Ch.B., D.P.H.	Deputy County Medical Officer.
G. S. Johnston, M.D., Ch.B., D.P.H. ...	Tuberculosis—Prevention and After-Care. (Part-time).
J. M. Anderson, M.R.C.S., L.R.C.P. ...	Senior Medical Officer for Maternity and Child Welfare.
J. A. Burgess, M.D., Ch.B., D.P.H. ...	Venereologist (Part-time).
A. F. Turner, M.B., B.Ch., D.P.H. ...	Senior Medical Officer for School Health.
C. C. Harvey, B.Sc., M.D., B.S., F.R.C.S., M.R.C.P.	Paediatrician.
H. J. O'Loughlin, M.B., Ch.B., L.R.C.P., D.P.M.	Mental Health (Part-time).
B. R. Townend, F.D.S., R.C.S., L.D.S. ...	Chief Dental Officer.
Vacancy	Psychiatrist.
Miss D. Walker	Superintendent Health Visitor.
Miss A. Carey	Area Superintendent Health Visitor.
Miss A. M. Clarke	Area Superintendent Health Visitor.
Miss R. O'Brien	Area Superintendent Health Visitor.
Miss M. D. M. Mitchell	Senior Health Visitor for Care of Unmarried Mother and her Child.
Miss G. M. Harvey	Supervisor of Midwives.
Miss E. M. Taylor	Supervisor of Midwives.
Miss H. Brooks	Supervisor of Day Nurseries.
Miss C. Bellamy	Supervisor of Day Nurseries.
Miss E. M. Greenwood	Superintendent Home Nurse.
Miss G. Jones	Assistant Superintendent Home Nurse.
Mrs. W. Taylor	Assistant Superintendent Home Nurse.
Vacancy	Senior Speech Therapist.
Mrs. M. I. Morrison	Domestic Help Organiser.
L. Butterworth (1), (2), (4), (5)	Acting Chief County Sanitary Inspector.
H. Tayler (1), (2), (6)	County Sanitary Inspector.
R. D. Irving (1), (2), (7), (9)	County Sanitary Inspector.
F. C. Brookes (1), (2)	County Sanitary Inspector.

CLERICAL STAFF

J. Colman (1), (3), (8)—Chief Clerk

Senior Clerks—J. W. Beaumont (1), H. Bywater, G. Richardson (7), A. Charlesworth,
J. H. Milne (7).

DIVISIONAL MEDICAL OFFICERS (25% School Health)

M. Hunter, M.B.E., M.D., Ch. B., D.P.H.	Division No. 1 (Skipton).
D. P. Lambert, M.D., Ch.B., D.P.H., D.T.M., D.T.H. ...	,, No. 2 (Settle).
H. M. Holt, T.D., M.B., B.S. (Lond.), M.B., Ch.B. (Leeds), D.P.H.	,, No. 3 (Keighley).
J. Battersby, M.B., Ch.B., D.P.H.	,, No. 4 (Shipley).
G. P. Holderness, M.B., Ch.B., D.P.H.	,, No. 5 (Pudsey).
R. A. W. Procter, M.C., M.A., M.B., B.Chir., M.R.C.S., L.R.C.P., D.P.H., D.T.M.	,, No. 6 (Otley).
N. V. Hepple, M.D., B.S., B.Hy., D.P.H.	,, No. 7 (Ripon).
D. D. Payne, M.D., B.S., M.R.C.S., L.R.C.P., D.P.H.	,, No. 8 (Harrogate).
R. G. Smithson, M.D., Ch.B., D.P.H.	,, No. 9 (Wetherby).
S. K. Appleton, M.D., Ch.B., D.P.H., D.T.M.	,, No. 10 (Goole).
J. M. Paterson, M.B., Ch.B., D.P.H.	,, No. 11 (Castleford).
J. F. Fraser, M.B., B.S., D.P.H., D.Obst.R.C.O.G. ...	,, No. 12 (Pontefract).
W. G. Evans, M.A., M.B., B.Ch., M.R.C.S., L.R.C.P., D.P.H.	,, No. 13 (Ossett).
F. G. E. Hill, D.S.O., M.B., Ch.B., D.P.H.	,, No. 14 (Morley).
J. F. Caithness, M.B., Ch.B., D.P.H.	,, No. 15 (Batley).

(1) Sanitary Inspectors' Cert. Royal Sanitary Inst.

(2) Cert. as Inspector of Meat and Other Foods, Royal Sanitary Inst.

(3) Exam. in Sanitary Science as applied to Buildings and Public Works, Royal Sanitary Inst.

(4) Final Cert. Builders' Quantities, London City and Guilds.

(5) Final Cert. (Distinction) Builders' Quantities, Lancashire and Cheshire Inst.

(6) Testamur—Inst. of Municipal and County Engineers.

(7) Diploma in Public Administration.

(8) Associate Chartered Inst. of Secretaries.

(9) Sanitary Science Cert. (Liverpool University).

DIVISIONAL MEDICAL OFFICERS—continued

A. L. Taylor, M.D., Ch.B., D.P.H., L.D.S.	...	Division No. 16	(Rothwell).
W. M. Douglas, M.B., Ch.B., D.P.H.	...	„ No. 17	(Mirfield).
F. Appleton, M.B., Ch.B., D.P.H.	...	„ No. 18	(Brighouse).
J. Lyons, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.	...	„ No. 19	(Todmorden).
E. Ward, M.R.C.S., L.R.C.P., D.P.H.	...	„ No. 20	(Colne Valley).
H. S. Bury, M.R.C.S., L.R.C.P., D.P.H.	...	„ No. 21	(Saddleworth).
J. Main Russell, M.B., Ch.B., B.Hy., D.P.H.	...	„ No. 22	(Wortley).
J. Warrack, M.B., Ch.B., D.P.H.	...	„ No. 23	(Hemsworth).
A. Reeves, M.A., M.D., B.Ch., B.A.O., D.P.H.	...	„ No. 24	(Cudworth).
R. S. Hynd, M.B., Ch.B., D.P.H.	...	„ No. 25	(Wombwell).
A. Eustace, B.Sc., M.B., B.Ch., B.A.O., L.M., D.P.H.	...	„ No. 26	(Wath).
J. Ferguson, M.B., Ch.B., D.P.H.	...	„ No. 27	(Adwick-le-Street).
A. Penman, M.D., Ch.B., D.P.H.	...	„ No. 28	(Doncaster).
G. Higgins, B.Sc., M.B., Ch.B., D.P.H., (commenced 13.2.50.).	...	„ No. 29	(Thorne).
J. Leiper, M.B.E., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.	...	„ No. 30	(Mexborough).
J. M. Watt, M.D., Ch.B., D.P.H., D.C.H., D.Obst.R.C.O.G.	...	„ No. 31	(Rotherham).

ASSISTANT COUNTY MEDICAL OFFICERS (50% School Health)

K. E. M. Allen, B.A., M.R.C.S., L.R.C.P.	...	(Division No. 28).
P. A. G. M. Ashmore, M.R.C.S., L.R.C.P.	...	„ No. 7).
E. M. R. Bell-Syer, M.B., B.S.	...	„ No. 10).
E. R. M. Bowker, B.A., M.B., Ch.B.	...	„ No. 16).
E. J. I. Brick, M.B., Ch.B.	...	„ No. 9).
*H. M. Bryant, M.B., Ch.B., D.P.H.	...	„ No. 8).
G. M. Buckle, M.B., B.S.	...	„ No. 4).
P. S. R. Burrell, M.B., Ch.B., D.P.H.	...	„ No. 9).
R. C. Davison, M.B., B.S.	...	„ No. 8).
B. R. A. Demaine, M.B., Ch.B., D.P.H.	...	„ No. 30).
C. M. Dornan, M.B., B.Ch.	...	„ No. 28).
D. E. Gledhill, M.B., Ch.B.	...	„ No. 3).
J. C. Goldthorpe, M.R.C.S., L.R.C.P.	...	„ No. 2).
*A. P. Gorrie, M.B., Ch.B.	...	„ No. 31).
*H. Gray, M.D., Ch.B., D.P.H.	...	„ No. 4).
I. Hargreaves, M.B., Ch.B.	...	„ No. 13).
S. G. A. Henriques, M.B., Ch.B.	...	„ No. 24).
M. A. Hillis, M.B., Ch.B.	...	„ No. 6).
*F. M. L. Holt, M.B., Ch.B., D.P.H.	...	„ No. 3).
R. B. Laidlaw-Becker, M.D., Ch.B., M.R.C.S., L.R.C.P., D.P.H., D.P.M.	...	„ No. 29).
B. M. Leakey, M.B., B.S.	...	„ No. 1).
J. A. Leitch, M.B., Ch.B., D.C.H., D.P.H.	...	„ No. 27).
H. F. Lindsay, M.B., Ch.B.	...	„ No. 30).
S. Lindsay, M.B., Ch.B.	...	„ No. 22).
*A. Marshall, M.B., Ch.B.	...	„ No. 18).
E. G. Matthews, M.R.C.S., L.R.C.P.	...	„ No. 25).
G. M. Mayhall, M.R.C.S., L.R.C.P.	...	„ No. 12).
M. R. Menzies, M.B., Ch.B.	...	„ No. 26).
H. M. Mitchell, M.B., Ch.B.	...	„ No. 5).
*J. R. Murdock, M.D., Ch.B., B.A.O., D.P.H.	...	„ No. 5).
M. M. Neil, M.B., Ch.B.	...	„ No. 4).
J. J. Pienkowski, M.B., Ch.B.	...	„ No. 23).
A. Seelig, M.D. (Strasbourg).	...	„ No. 18).
*W. G. Smeaton, M.B., Ch.B., D.P.H.	...	„ No. 20).
J. J. Smith, M.B., Ch.B., D.P.H.	...	„ No. 23).
F. D. F. Steede, M.B., B.Ch., B.A.O.	...	„ No. 27).
D. M. Summers, M.B., Ch.B.	...	„ No. 16).
*J. M. Taggart, M.B., Ch.B., B.A.O., D.P.H.	...	„ No. 22).
*J. S. Walters, M.B., Ch.B., D.P.H.	...	„ No. 11).
E. M. Whitehead, M.B., Ch.B.	...	„ No. 17).
*G. A. Wilthew, B.Sc., M.B., B.S.	...	„ No. 19).

* Deputy Divisional Medical Officer

SCHOOL OCULISTS (100% School Health)

R. Burns, M.B., B.Ch., B.A.O.
F. Fischer, M.D. (Vienna).

J. V. Kirkwood, M.B., Ch.B., D.P.H.
L. Wittels, M.D. (Vienna), D.O.

AREA DENTAL OFFICERS (95% School Health)

J. M. Enderby, L.D.S.
O. A. Long, L.D.S.

H. Marshall, L.D.S.
R. Sclare, L.D.S.

SCHOOL DENTAL OFFICERS (95% School Health)

W. J. Brown, L.D.S.
G. H. Bulcock, L.D.S.
F. W. Buzza, L.D.S.
B. C. Clay, L.D.S.
W. H. Dyke, L.D.S.
W. H. Etheridge, L.D.S.
M. M. Gibson, L.D.S.
V. F. H. Golledge, L.D.S.
J. Haddow, L.D.S.
M. Hattan, L.D.S.
S. Henry, L.D.S.
A. M. Holburn, L.D.S.
R. Jackson, L.D.S.
F. Kershaw, L.D.S.
S. Levinson, L.D.S.

J. Mackay, L.D.S.
E. S. Midgley, L.D.S.
R. T. Mosbery, L.D.S.
D. B. Owen, L.D.S.
M. H. Platford, L.D.S.
F. H. Sanderson, L.D.S.
M. E. Skelton, L.D.S.
B. Sleight, B.Ch.D., L.D.S.
H. Taylor, L.D.S.
M. Thom, L.D.S.
E. Thornton, L.D.S.
J. Todd, L.D.S.
B. Watts, L.D.S.
G. O. Wood, L.D.S.
H. M. Yuile, L.D.S.

HEALTH VISITORS, MIDWIVES, MEDICAL AUXILIARIES, etc.

- 4 Psychiatric Social Workers (to be appointed).
- 276 Health Visitors and School Nurses.
- 5 Orthopaedic Nurses.
- 25 Tuberculosis Visitors.
- 4 Venereal Diseases Social Workers.
- 1 Supervisor of Home Teachers and Social Workers (to be appointed).
- 1 Mental Health Home Teacher.
- 11 Mental Health Social Workers.
- 246 Midwives.
- 272 Home Nurses.
- 45 Dental Attendants.
- 4 Speech Therapists (three part-time).
- 5 Physiotherapists (part-time).

COUNTY ANALYST (Part-time)

F. W. Richardson, F.R.I.C., F.R.M.S.
F. W. M. Jaffe, B.Sc., F.R.I.C. (Deputy).

DAY NURSERIES

- 24 Day Nurseries—total nursing staff 179.
- 1 Nursery Nurses Training Hostel, One Oak, Ilkley.

ANTE-NATAL HOSTEL

Clifton, Brighouse. Matron Miss F. E. Allen. Nursing Staff 1.

MENTAL HEALTH OCCUPATION CENTRE

Castleford. Staff—1 Supervisor; 2 Assistant Supervisors, and 2 Nursery Assistants.

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